# Siskiyou Community Health Center

## AUTHORIZATION FOR DENTAL HYGIENE SERVICES

Siskiyou Community Health Center offers you and/or your child the opportunity to receive dental hygiene exams, plaque removal and fluoride varnish treatments through our Dental Prevention Program. These services are available regardless of income or insurance status. We will bill your insurance company when possible. **If you or your child does not have insurance**, you may be eligible to receive these services at no cost under our Dental Prevention Sliding Discount Program. To be considered for this discount, please complete the attached application.

If you would like you or your child to receive these services, please answer the questions below, sign and date. ***Please print all information.***

Patient's Name: _____ Date of Birth: _____ ❒ Male ❒ Female

Medical Insurance (please circle): AllCare Health Plan CCO Primary Health of Josephine County CCO Other

Patient's Dental Insurance (please circle): Capitol Advantage ODS Open Card Willamette Private None

Insurance Patient ID#: _____ Parent/Guardian: _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Phone # Home: _____ Work: _____ Message: _____

**Answer the questions below for person receiving services:**

1) Is there a history of asthma?
   ❒ No ❒ Yes

2) Are there serious health problems?
   ❒ No ❒ Yes Please explain: _____

3) Do allergies exist?
   ❒ No ❒ Yes Please list: _____

4) Currently taking prescription fluoride tablets or drops?
   ❒ No ❒ Yes

5) Are there dental problems?
   ❒ No ❒ Yes Please explain: _____

6) Date of last dental exam: _____

7) Dentist Name: _____

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**Please provide the following patient information for our statistics. This will not affect eligibility to receive services.**

**Relationship Status**
- ❒ Single (use for child)
- ❒ Married
- ❒ Widowed
- ❒ Other

**Employment Status**
- ❒ Full-time
- ❒ Part-time
- ❒ Retired
- ❒ Unemployed
- ❒ Disabled

**Student Status**
- ❒ Enrolled in Head Start
- ❒ Full-time
- ❒ Part-time
- ❒ Not Applicable

**Primary Race**
- ❒ American Indian/Alaskan Native
- ❒ Asian
- ❒ Black/African American
- ❒ Caucasian (White)
- ❒ Hispanic/Latino
- ❒ Native Hawaiian/Pacific Islander
- ❒ Other

**Primary Language**
- ❒ English
- ❒ Sign Language
- ❒ Spanish
- ❒ Other

**Information/Income for Family**
- ❒ Gross Monthly Income $ _____
- ❒ Number of people in household _____
- ❒ Refuse to Answer

I hereby give consent for me or my child to receive dental hygiene education, examinations and fluoride varnish treatments as recommended during the year. I also give consent for exchange of information between Siskiyou Community Health Center, Southern Oregon Head Start, WIC, Insurance carrier and the dentist of record. This consent will remain in effect for 36 months. By signing this form I also acknowledge that Siskiyou Community Health Center complies with the HIPAA Privacy Practices Act and a copy of that notice is available onsite. (*For a full copy of our HIPAA Privacy & Security Act, see our website at www.siskiyouhealthcenter.com*)

Signature: _____ Date: _____

*Patient or Parent/Guardian Signature*