Smiles@School
Atchison Community Health Clinic

2022-2023 School Year

SAVE TIME!
Call 913-336-2070 to sign up your child over the phone or register using this link:

☐ **Check here if your child has a dental home and you DO NOT want your child to have dental services at the school**

Student Information

Student Last Name (Legal):	Student First Name (Legal):	MI:	Preferred Name:

Student DOB:

Student Sex at Birth: ☐ Male ☐ Female

Parent Home Phone #: ☐ Permission to leave voicemail

Parent Cell #: ☐ Permission to leave voicemail

Is the student homeless? ☐ Yes ☐ No

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic

Student Gender Identity: Innermost concept of self as male, female, both, or neither
- ☐ Male
- ☐ Female
- ☐ Transgender Male (F to M)
- ☐ Transgender Female (M to F)
- ☐ Something Else:
- ☐ Choose not to disclose

Student Race:
- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White/Caucasian

Student Address:	City:	State:	Zip:

Kansas Medicaid Benefits

Does the student have KanCare? ☐ Yes ☐ No

☐ **KS Medicaid** ☐ **Sunflower** ☐ **United Healthcare** ☐ **Aetna**

KanCare Policy ID#:

Dental Insurance Information

Primary Dental Insurance Company:	Primary Dental Insurance Address:	Insurance Group #:

Subscriber First and Last Name:	Subscriber Date of Birth:	Subscriber Social Security #:

Insurance Policy #:

Responsible Party/Parent/Guardian Information

Last Name:	First Name:	MI:

Social Security #:	Phone Number:	Date of Birth:

Email Address:

Emergency Contact:

Name:	Relationship to Student:	Phone #:

Consent to Treat

Your child's school has agreed to work with Atchison Community Health Clinic (ACHC) and their school based dental program called Smiles @ School, to provide space for dental services. I give ACHC permission to provide dental services to my child. I acknowledge that the Privacy Practices were and are available for my review. I hereby state, to the best of my knowledge, the above information is complete and correct. I authorize ACHC to submit all services to my insurance company and to collect payment on my behalf. I understand that I am responsible for any co-pay, deductible, or non-covered services. I understand ACHC offers a sliding fee discount. If interested in applying for the discount or you have questions about your bill, please call the ACHC billing office at 913-367-4879.

Parent/Guardian Name:	Parent/Guardian Signature:	Date:

2022 Annual Federal Poverty Guidelines

Please note, the federal government requires us to ask you for the following information. It is used for government reporting purposes only. No identifying information will ever be disclosed, including name, and we will not use this information for any other purpose.

PLEASE CHECK THE BOX NEXT TO YOUR HOUSEHOLD SIZE AND INCOME

1 Person in Household	2 People in Household	3 People in Household	4 People in Household
☐ $0.00 - $13,590	☐ $0.00 - $18,310	☐ $0.00 - $23,030	☐ $0.00 - $27,750
☐ $13,591 - $16,852	☐ $18,311 - $22,704	☐ $23,031 - $28,557	☐ $27,751 - $34,410
☐ $16,853 - $20,249	☐ $22,705 - $27,282	☐ $28,558 - $34,315	☐ $34,411 - $41,348
☐ $20,250 - $27,180	☐ $27,283 - $36,620	☐ $34,316 - $46,060	☐ $41,349 - $55,500
☐ $27,181 +	☐ $36,621 +	☐ $46,061 +	☐ $55,501 +

5 Person in Household	6 People in Household	7 People in Household	8 People in Household
☐ $0.00 - $32,470	☐ $0.00 - $37,190	☐ $0.00 - $41,910	☐ $0.00 - $46,630
☐ $32,471 - $40,263	☐ $37,191 - $46,116	☐ $41,911 - $51,968	☐ $46,631 - $57,821
☐ $40,264 - $48,380	☐ $46,117 - $55,413	☐ $51,969 - $62,446	☐ $57,822 - $69,479
☐ $48,381 - $64,940	☐ $55,414 - $74,380	☐ $62,447 - $83,820	☐ $69,480 - $93,260
☐ $64,941 +	☐ $74,381 +	☐ $83,821 +	☐ $93,261 +

Medical History Information

When did your child last visit a dentist?

☐ In the past year
☐ More than a year ago
☐ Never

Why did your child visit the dentist last?

☐ Checkup ☐ Filling
☐ Cleaning ☐ Tooth Pulled
☐ Mouth Pain ☐ Other

Medical History:

☐ Heart Murmur ☐ Autism
☐ Seizure Disorder ☐ Asthma
☐ Artificial Heart Valve ☐ Diabetes
☐ Heart Disease ☐ Hepatitis
☐ Artificial Joints, Pins, Screws ☐ Other:

Allergies:

☐ Latex
☐ Amoxicillin/Penicillin
☐ Other:

Is your child required by physician to take premedication (antibiotics) prior to dental treatment? ☐ **Yes** ☐ **No**
If yes, for what condition:

Does your child have special needs? ☐ **Yes** ☐ **No**
If yes, please explain:

Surgeries/Hospitalization/Other Medical Conditions? ☐ **Yes** ☐ **No**
If yes, please list.

Is your child currently taking any medications? ☐ **Yes** ☐ **No**
If yes, please list medications

Please tell us anything we should know about your child's health or previous dental experiences that would help us treat your child or meet their needs.

I confirm the above information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

Parent/Guardian Signature: **Date:**