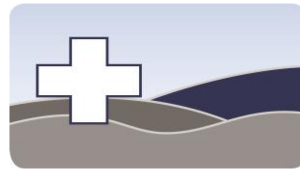
Student Information



FLINT HILLS
COMMUNITY HEALTH CENTER
YOUR HEALTH ✚ MORE

Chart # ______________

Grade________ Teacher______________________________ School ___________________________________

DOB____/____/____ Age_____ Gender ☐ Male ☐ Female Phone #___________________________________

Student Name ____

Street Address____ Apt. #_______

City____________________________________ State ______ Zip Code __________

Parent/Guardian Name_________________________ Relation to Student ________

Street Address____ Apt. #_______

City____________________________________ State ______ Zip Code __________

Race/Ethniciy (check all that apply)

- ☐ White
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Black/African American
- ☐ Native Hawaiin/Pacific Islander
- ☐ Hispanic
- ☐ Other

Please mark the box next to each service you would like your child to receive:

☐ Sealants ☐ Cleaning ☐ Fluoride

Health History (required)

- ☐ Diabetes
- ☐ Heart murmur
- ☐ ADD/ADHD
- ☐ Anxiety/Depression
- ☐ Artificial Joints Pin/Screws
- ☐ Heart Disease
- ☐ Autism
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Hepatitis
- ☐ Seizure disorder
- ☐ Congenital Heart Disorder
- ☐ Other__________________

Any known allergies?

- ☐ Latex
- ☐ Amoxicillin/Penicillin
- ☐ Other______________

Please list all medications your child is currently taking ____

____

Does your child require a pre-medication (antibiotic) prior to dental treatment? ☐ Yes ☐ No

Name of child's dental home and date of last visit ____________________________ ____/____/____

Insurance Information (required) Please fill out the following information about your CHILD:

☐ Sunflower ☐ Amerigroup ☐ United Health Care ☐ Private ☐ None

Name of subscriber (individual who carries the insurance) ____

Name of dental insurance company_______________________________ ID #__________________

Group #_________________

Policy Holder's SS#________________ Policy Holder DOB____/____/____ Employer _______________________

I give permission to Flint Hills Community Health Center to provide preventative dental services for my childand to collect payment from Kancare and/or my private insurance.

____ ____________________

Parent/Guardian Date