



Please print all patient information clearly.

Today's date: _____

Student Name: _____ DOB: _____ School: _____

Mailing Address (PO Box): _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Responsible Party Name: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Alt. Phone: _____

Insurance Company: _____ Policy # _____ Group# _____

Insurance Subscriber Name: _____ DOB: _____ SS# _____

Address (if different then above): _____

I _____ give permission for my child /children named below to have the following services provided as deemed necessary by the dental professional: I understand that these services are considered to be preventive in nature and other restorative treatment may be deemed necessary the oral health provider. I understand that if my child requires further treatment, the oral health provider school nurse will assist me in accessing such treatment.

- Educational instruction:** Proper brushing and oral hygiene
- Dental assessment:** An evaluation of the teeth and soft tissue
- Fluoride varnish:** A protective treatment for the teeth
- Sealants:** A protective barrier placed on molars

I understand that by signing this agreement that I am in no way financially responsible for the screening provided by Plains Medical Center under this school based program.

I hereby authorize PLAINS MEDICAL CENTER to release to my insurance company or its representative any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental services. I also authorize and request my insurance company to pay directly to PLAINS MEDICAL CENTER the amount due me in my pending claim for preventative dental services. Furthermore, I authorize PLAINS MEDICAL CENTER to correspond with the Insurance Commissioner on my behalf should this become necessary. When available, all services rendered will be billed to your insurance carrier.

The services of Plains Medical Center that are necessary for your care are without regard to race, color, creed, national origin, age, sex, sexual preference, political party, religion or disability.

Print Parent/Guardian Name: _____ Signature: _____

Return Permission Form to School Secretary

Strasburg Clinic
55981 E. Colfax Avenue
P.O. Box 1219
Strasburg, CO 80136
Ph: (303)622-9237

Limon Clinic
820 1st Street
P.O. Box 1120
Limon, CO 80828
Ph: (719)775-2367

Kiowa Clinic
320 Comanche Street
P.O. Box 314
Kiowa, CO 80117
Ph: (720) 389-9763

Flagler Clinic
305 Pawnee Avenue
P.O. Box 386
Flagler, CO 80815
Ph: (719) 765-4777