Dental Care Coordination
Consent for Dental Care

All Smiles Community Oral Health is working with your child's school to provide free dental care coordination. With your consent, we will help you find dental care in your community. Please complete the form below so we can begin getting your child the help they need right away.

Name of Child: _____
(Last) (First) (Preferred Name)

Child's Date of Birth (mm/dd/yy): _____ /_____ /_____ Grade: _____

School: _____

Contact Information	
Parent/Guardian Name:	
Best phone number to reach you:	Permission to Text: ☐ Yes ☐No
Email address:	
Mailing address:	
Language spoken at home:	

Please provide the following information so we can better serve your child:

My child is experiencing (check all that apply):

☐ Pain ☐ Swelling ☐ Bleeding ☐ Mouth Sores ☐ Discomfort ☐ Broken Tooth ☐ Other _____

My child is taking (list medications):	None: ☐
My child is allergic to:	None: ☐
Any current medical problems:	None: ☐
Any behavioral considerations:	None: ☐
Other information to help us better serve your child:	None: ☐

Please complete the section below. You will not receive a bill.

Health Insurance: ☐ Oregon Health Plan (OHP) / Medicaid ID# _____ ☐ Private dental insurance company _____ ☐ No health insurance	Care Coordination for your family is free. You will not receive a bill.

By signing below you:

As the legal parent/guardian, I hereby consent to the release and exchange of information, including any relevant personal health information, between the All Smiles Community Oral Health and Collaborating partner providers, school staff, insurance carriers, the child's dentist, applicable Coordinated Care Organization, and/or the Dental Care Organization of record. I have received a copy of "Notices of Privacy Practices." Privacy Practices are available on the All Smiles website AllSmilesCOH.org/forms.

Parent/Guardian Signature: _____ Date: _____