STUDENT ORAL HEALTH FORM

Patient Information

Childs name (last, first, MI) _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Parent or Guardian _____ Phone _____

Oral Health Service

Please select one applicable box and fill in the date below:

Date of Service:	School Entry	2nd Grade	7th grade	12th grade
	☐	☐	☐	☐

Type of Oral Health Services Provided: **Dental Examination**

Does the child have any teeth with untreated decay? Yes (decay) No (decay free)

Does the child have any previously decayed, filled, or extracted teeth? Yes No

Decay and other treatment needs? Yes, urgent Yes, not urgent No

Additional Information

Oral Health Provider's Contact Information and Signature

H E Henry, DDS
200 Saint Thomas Drive, Weirton, WV 26062
Voice: 304-723-7200
Fax: 304-723-4460

_____ _____ _____

Provider Signature State Dental License Date

HIPAA CONSENT HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
FERPA CONSENT FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT

AUTHORIZATION FOR USE AND OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICAL AND DENTAL HEALTH CARE PROVIDERS AND SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested below may invalidate this authorization. Signing this authorization may be required in order for this student to obtain appropriate services in the educational setting.

Student Patient Name: _____ ___/___/___
(Last) (First) (MI) DOB

Health Care Provider:

H E Henry, DDS 200 Saint Thomas Drive, Weirton, WV 26062 (304) 723-7200

Requestor:

School District: _____

School District Address: _____

School Contact Person: _____ Telephone: _____

USE AND DISCLOSURE INFORMATION

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature, or until _____ (enter date).

RESTRICTIONS: Law prohibits the Requestor from making further disclosure unless the Requestor obtains another authorization form or unless such disclosure is specifically required or permitted by law.

RIGHTS: I understand that the patient has rights with respect to this Authorization, and that this Authorization may be revoked at any time by the patient or on behalf of the patient if delivered to the school district / healthcare agency / or contact person listed above in writing. The revocation will be effective upon receipt, but will not be retroactive to the extent that the Requestor or others have already acted in reliance to this Authorization. I, the undersigned, have a right to receive a copy of this Authorization.

REDISCLOSURE: The requested information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs. The Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA), and the information becomes part of the student's educational record.

APPROVAL: I, the undersigned, do hereby authorize the above health care provider to provide requested information to and from the patient's dental or medical records limited to all minimally necessary health information, or disease-specific information as described: _____

Signature: _____ Date_____

Printed Name: _____ Telephone: _____

Relationship to Student Patient: _____