Dental Screening Consent Form

North Olympic Healthcare Network
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*****If the patient requesting a dental screening is a MINOR, this Oral Health Screening & Fluoride Varnish Consent Form must be signed by the patient's parent, guardian, or representative.*****

Patient Information

Full Name _____
Date of Birth _____
Preferred language _____
Preferred Phone # _____

Parent/Guardian/Representative Information

Full Name _____
Date of Birth _____
Preferred language _____
Preferred Phone # _____

Insurance/Billing Information

Insurance Plan/Company _____
Policy Number _____
Group Number _____
Subscriber Name _____
Subscriber Date of Birth _____
Subscriber's Relationship to Patient _____
Would the patient like assistance applying for insurance or NOHN's Sliding Fee Scale? (If yes, a NOHN Outreach Worker will attempt to contact you) ☐ Yes ☐ No

I understand that by signing this form I am consenting for the patient named above to receive a basic oral health assessment, or dental screening. I understand that this screening is only a very basic evaluation and does not take the place of a thorough dental examination necessary to establish and maintain oral health.

I also understand that receiving this dental screening does not establish any new, ongoing, or continuing doctor-patient relationship. I am free to establish such a doctor-patient relationship in the future with the dentist performing this screening or another dentist of my choice. Further, I will not hold the dentist or those performing this assessment responsible for the oral health consequences or results should I choose NOT to follow the recommendations of the provider.

☐ **I do consent for a fluoride varnish to be applied to the patient's teeth.**

☐ **I would like to establish the patient and/or myself as a patient at North Olympic Healthcare Network Family Dentistry. Please contact me to discuss next steps.**

Parent/Guardian/Representative's Signature **Date Signed**