When You Need Health Care, Call First Care!

1301 Main St.
Hays, KS 67601
785.621.4990

105 W. 13th St.
Hays, KS 67601
785.621.4990

1923 E. 22nd St.
Hays, KS 67601
785.621.4990

www.firstcareclinic.com
Fax: 785.628.8719

Fluoride Consent Form

Student Information

First Name: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Phone Number: _____ Date of Birth: _____ Gender: _____

School: _____ Grade: _____ Teacher: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Other Pacific Islander ☐ White ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Insurance: ☐ No Dental Insurance ☐ KanCare – Provide ID #: _____
☐ BCBS Dental, Delta Dental or Other Private Dental Ins. – Complete Below

Insured Name: _____ Insured Date of Birth: _____

Relationship to Student: _____ Insured SSN: _____

Name of Insurance Company: _____

Phone Number on Back of Card: _____

Policy #: _____ Group #: _____

FCC covers the cost of services but requires all available dental insurance information for billing purposes. You will not be responsible for paying for any portion of these services, but if you have dental coverage, then your insurance carrier will be billed. By signing below, you hereby authorize FCC to release the information requested by your insurance company necessary to process claims and authorize payment to FCC. FCC staff will treat all patient information as protected health information (PHI) under HIPPA regulations, and will exchange the PHI only with FCC staff, the facility/school officials who are responsible for treatment and/or record review, and his/her medical or dental providers. I understand and consent to services from FCC staff for the above-named child.

Parent/Guardian Name: _____ Phone #: _____

Parent/Guardian Signature: _____ Date: _____