| Name | MC Ver N R | Fall | MC ReVer | Spring |
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# Prevention Works Dental Hygiene 2021/2022

Dear Parent or Guardian,

**If you do <u>not</u> wish for your child to participate in the school dental clinic, *<u>DO NOT FILL OUT THIS FORM.</u>***

A Dental Hygienist will see your child during school hours to provide oral inspections, cleanings, oral hygiene instructions, fluoride varnish, sealants, temporary fillings, and/or Silver Fluoride (SF.) SF is used to temporarily manage cavities until your child can get permanent fillings from a dentist. When decay is treated with SF, the tooth will turn dark. This is a good indication that the infection in the tooth is dying. If you do **<u>not</u>** want SF used, please check this box ☐. A report will be sent home with our findings. **Please complete and return this permission slip ONLY if you would like your child to participate.**

If there are any medical changes in the health of the child during the year, please notify the school nurse. We will notify the school nurse if your child needs emergent care. Parents/guardians that choose self-pay will be contacted by Prevention Works before the clinic date to discuss services, cost, and payment procedure. Parents/guardians that choose to withdraw child after enrolling must contact Prevention Works. **THIS PROGRAM DOES NOT REPLACE AN EXAM BY A DENTIST.**

If you have any questions, please call Alissa Wade, IPDH at 207-949-2963

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**Child's Name:** _____ **Date of Birth:**_____-_____-_____ **Sex**: **M**____ **F**____

**(As it appears on Insurance card, PLEASE PRINT CLEARLY)**

**School Name:** _____ **Teacher:** _____ **Grade:** _____

☐ **MaineCare**

#_____

(9-digit number on front of card)

☐ **Self-Pay (includes cleaning and fluoride varnish)**

☐ 12 or younger ($50.00) ☐ 13 or older ($60.00)

☐ Cash ☐ Money Order (payable to Prevention Works)

Debit/Credit card #_____

Name on Card: _____

Expiration date:_____ 3-digit code:_____ Billing ZIP code:_____

☐ **Dental Insurance (MUST be complete. ALL information is required. A copy of both sides of card is helpful)**

Insurance Company:_____

Insurance Co. claims address:_____ Zip Code:_____

Phone:_____ ID Number:_____ Group Number:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Home Address: _____

City/Town_____ Zip Code_____

Parent/Guardian Phone Numbers (check best) ☐ Home:_____ Cell:_____ ☐ Work:_____

Allergies, Current Medications, Medical Conditions: _____

_____

Do you have any dental questions or concerns?_____

Has s/he seen a dentist or hygienist? Y___N___ Date of last visit_____-_____-_____

Dentist's Name of location of last visit:_____

*Yes, I give permission for my child to be seen <u>throughout the school year.</u> I will notify the school nurse of any changes in the medical history. I understand that Prevention Works is HIPAA compliant and all records are kept confidential and that claims to MaineCare insurance will be electronically transferred.* ***By signing below, you are giving Prevention Works to share medical/dental information with other health professionals.***

**Signature**:_____**Date**:_____

**Please PRINT your name**_____