

## Optional-Dental-Prevention Works

### **IF YOU DO NOT WANT YOUR CHILD TO PARTICIPATE OR THEY ALREADY HAVE A DENTIST-DO NOT FILL OUT THIS FORM.**

A Dental Hygienist will see your child during school hours (twice per year) to provide: oral screening, dental cleaning, fluoride varnish, oral hygiene instructions, sealants, temporary fillings and/or Silver Fluoride (SF.) SF is used to temporarily manage cavities until your child is able to see a dentist for permanent fillings. When cavities are treated with SF, the tooth will turn dark, which is a good indication that the infection in the tooth is dying. If you DO NOT want SF used, please check this box **IF YOU WANT YOUR CHILD TO BE SEEN-THE ENTIRE FORM MUST BE COMPLETED OR IT WILL BE RETURNED TO YOU TO COMPLETE. THIS PROGRAM DOES NOT REPLACE AN EXAM BY A DENTIST.**

FULL NAME OF STUDENT- PLEASE PRINT CLEARLY: \_\_\_\_\_ GENDER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

#### **PARENT/GUARDIAN INFORMATION:**

PARENT/GUARDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ EMERGENCY #: \_\_\_\_\_

**PLEASE PROVIDE THE REQUESTED INFORMATION BELOW, AS IT MAY BE NEEDED IN CASE OF EMERGENCY. IF THERE ARE NONE-PLEASE PUT N/A**

MEDICAL CONDITIONS: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

Do you have any dental questions/concerns? \_\_\_\_\_

Has your child seen a dentist or hygienist? Yes \_\_\_ No \_\_\_ Date of last visit: \_\_\_\_\_

Dentist's Name or location of last visit: \_\_\_\_\_

**IF YOU WOULD LIKE TO BE SELF PAY-you will be contacted by Prevention Works before your child's visit to discuss services, cost, payment procedure.**

12 or younger-\$55 (includes cleaning & fluoride varnish)

13 or older-\$65 ((includes cleaning & fluoride varnish)

Sealants- \$20 per tooth (usually recommend on 6 and 12 year molar teeth)

**WE WILL ACCEPT THE FOLLOWING DENTAL INSURANCE: MAINECARE, DELTA DENTAL, UNITED HEALTHCARE, CIGNA, AND PATIENTS ADVOCATES.**

**PLEASE FILL OUT INSURANCE SECTION ENTIRELY. A COPY OF BOTH SIDES OF THE INSURANCE CARD IS HELPFUL.**

**DENTAL INSURANCE:** \_\_\_\_\_ PLEASE PRINT CLEARLY

Company Name: \_\_\_\_\_ Policy/ ID # \_\_\_\_\_ Group: \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber's Address \_\_\_\_\_

Insurance company provider line phone number: \_\_\_\_\_

I hereby give permission for my child to be seen throughout the school year. I understand that Prevention Works is HIPPA 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 authorization to share medical/dental information with other healthcare professionals.**

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

