OPTIONAL Dental Hygiene Services at School

If you would like your child to have dental hygiene services by an independent dental hygienist at school fill out this form. If your child is being seen in a dental office and you do not wish him/her to have services at school do not fill out the form. Any questions call 949-2963.

If needed, all services will be provided unless you request otherwise:

Cleaning, Fluoride, Sealants, and Temporary Protective Restoration.

If there is any concerns with your child's oral health and I am unable to speak to a parent or guardian, a message will be left on the number given below. If you prefer no message to be left on the phone please indicate so by checking this box. ( )

Childs Name: ________________________ Date of Birth: _________ Address: _________________________
Parent/Guardian: _____________________________ Phone # (cell/home): __________________________
School: ________________ Teacher: ______________ Grade: ______ Name of Dentist: ________________
Date of last dental Visit: _______ Dental Concerns: ____
Name and Number of Physician: _______________________________ **PINENUT OR PEANUT ALLERY: Y/N**
List Allergies: ________________________________ List Medications: _______________________________
List Any or All Medical Conditions: ____
Does Your Child Need **Premedication** (antibiotics) prior to dental appointment: Y/N Why? ___________

_ _ ***No Insurance/Self Pay*** Payment is due at day of service. Method of payment accepted is cash/checks/money order payable to Prevention Works with a $20 fee for insufficient funds.

__ $52.00 Cleaning & Fluoride 13 & up __$42.00 Cleaning and fluoride 12 and under
__$30.00 Protective Restoration __$16.00 Each Sealant, total # of teeth _____

__ ***MaineCare*** ID # ________________________

__ ***Dental Insurance*** Insurance Name & Phone Number: ___________________Name of Subscriber & DOB: _______________________ Subscriber ID: ____________________Group ID# ______________

I give permission for my child to receive dental hygiene services which are listed above unless indicated otherwise. I acknowledge these services are completed by an independent dental hygienist, not a dentist and does not take the place of dental exams. I understand my child will be seen twice a year. I am aware that if I do not have insurance or if my insurance fails to pay I am responsible for the out-standing balance. I agree to notify the school nurse or Prevention Works of any changes in my child's medical history. I understand that Prevention Works follows HIPAA confidentiality requirements of patient records. In order to provide my child with the proper care, I give my permission to request or release confidential dental and health information pertaining to my child. This may include but is not limited to receiving of payment, previous dental records, referrals, or information released to the school nurse or Prevention Works.

Print Name____________________________________ Signature____________________________ Date______