Dental Prophylaxis (Cleaning), Dental Hygiene Screening, Fluoride Application, Dental Sealants, Radiographs (x-ray) Temporary Fillings, Oral Hygiene Instruction, Education on Dietary Risks for Decay, and Referrals

Saving Smiles of Maine

www.savingsmilesofmaine.org

Preventive Dental Care

If your child is being seen every 6 months for an exam by a dentist or for a dental cleaning and fillings, do not fill out this form, as she /he does not qualify for this service.

Student Name:_____**DOB**:_____Male/Female

Address: _____ **Zip**:_____

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

MaineCare ID# ____/____/____/____/____/____/____/____/____/ A Participate in Free or Reduced Lunch? Yes or No

MEDICAL: Physicians or Office Name:_____Phone:_____

MEDICAL CONDITIONS: Please list any condition requiring medication - heart problems, diabetes, kidney disease, ADD, etc.

_____

_____

ALLERGIES: Please list all allergies –milk, red dye, latex, food, medications, etc.

_____

Does your child have an Epi Pen at school? Yes or No

Does your child have any special physical or mental concerns that we should be aware of?

_____

DENTAL: Circle Previous Provider: Saving Smiles Program – Dentist – IPDH **Name**:_____

Date Last Seen : Month_____/_____Year Do you have well water? Yes or No

Saving Smiles HIPPA Policy Disclosure: This personal information will not be shared with anyone other than listed below and included in our HIPPA form. If you would like a copy of Saving Smiles of Maine HIPPA Policy, you may obtain one by contacting us via our website at www.savingsmilesofmaine.org or you can download a copy from our website.

Consent to Treat: In signing this form, I grant Saving Smiles of Maine permission for all above listed preventive dental hygiene services to be rendered to my child by a public health dental hygienist. I understand that the services that will be delivered do not take the place of a comprehensive examination by a licensed dentist. If necessary, permission is granted Saving Smiles of Maine to request or release confidential information on the above named child for the purpose of assessing eligibility, health assessment, providing further care, in making referrals, and for the benefit of the child. This applies to information exchanged to and from the school, the school nurse, from physician's office, from previous dentists, in assessing need for service, to dentists for further care and as requested from parent/legal guardian with signed permission of record transfer.

Date:_____(Print) Parent or Guardian:_____

Signature:_____Phone#:_____Relationship:_____

Photograph Consent: Please sign below to grant Saving Smiles of Maine permission to take photographs of your child to use in one or allof our media outlets:

Parent/Guardian Signature:_____Date:_____