

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. ()

Child's 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 ALLERGY: 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 outstanding 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 _____