Tooth Protectors Inc.

School Dental Hygiene Program Permission Form 2016-2017 School Year

Patient Consent & Medical/Dental History

P.O. Box 314 Lewiston, Maine 04243 Office (207) 513-1111 ToothProtectors.org

If your child is being seen **EVERY SIX (6) MONTHS** by a dental provider other than Tooth Protectors at school, for either an exam by a dentist, or a dental cleaning and fillings (if needed) **do not fill out this form as she/he does not qualify for the service.**

THIS FORM PROVIDES PERMISSION FOR YOUR CHILD TO BE SEEN TWO TIMES DURING THIS 2016-2017 SCHOOL YEAR FOR DENTAL CARE. PLEASE FILL OUT ONE FORM PER CHILD

GENERAL INFORMATION: *School Name:*_____ *Teacher/Grade:*_____

Child's Full Name:_____ Date of Birth: _____/_____/_____ Male / Female

Mailing Address:_____Town:_____ Zip Code:_____

Home Phone:_____ Cell: _____ Email:_____

DENTAL SERVICES: Must Choose 1 Service Below

____ **Full Dental Cleaning, Review, Fluoride & Sealants** ***(if recommended)*** – Only if your child has not had a cleaning within the past 6 months.

____ **Review** – This is **NOT** a Dental Cleaning- this is an Educational Review of proper brushing, flossing & fluoride treatment ***(sealants placed on those with insurance)***

PAYMENT METHOD: Must Choose 1 Form of Payment Below ***Accepted insurance is subject to change without notice***

Accepted Payment Options: ***MaineCare & most dental insurance, Cash, Check, Money Order, and Credit Cards*** ***(MC, Visa, Discover, American Express - note there is a $3.00 service fee)***

****If you have Dental Insurance & MaineCare, please provide information for both. The Dental Insurance will be billed first, if denied MaineCare will be billed for services.***

___ **MAINECARE INSURANCE**- ID # for Child: _____A_____

___ **OTHER DENTAL INSURANCE-** Ins. Company Name:_____ Policy Holders Full Name:_____ DOB:_____

Group #_____ Policy/Subscriber ID#:_____ Dental Provider Phone# ***(on back of Ins Card)*** _____

Please send a copy of your insurance card front & back – attach to this permission form or take a picture of your card on your phone and either FAX: (207) 513-1197, EMAIL: Info@ToothProtectors.org, TEXT: (207) 689-7900 to TPI Office.

___ **SELF PAY PAYMENT METHOD:** ☐ *Check #_____* ☐ *Cash* ☐ *Money Order* ☐ *Credit Card* ***(I have called TPI (207) 513-1111 and made this payment)***

- ✓ **ATTACH *Cash, Check, or Money Order***, in the exact amount to this COMPLETED permission form and return form & payment to your child's School
- ✓ **Please make Check/MO payable to: *TPI or Tooth Protectors Inc.*,** NOT THE SCHOOL NAME - **There will be a $25.00 fee for insufficient funds**
- ✓ **Please make out a Separate Check for Each Child being seen & write your child's Full Name in the Memo Line of your check**
- ✓ To pay by ***Credit Card***, call our office at **207-513-1111** to make payment and return this COMPLETED permission form to the School

Services I want my child to receive: ***(Check the services from left to right. Then add up & total to the right)***

☐ My child is age **12 or Under**, for ☐ **$55.00 - Full dental cleaning, Review** ☐ **Fluoride treatment $15.00** ☐ **Sealants $20.00** ***per tooth*** ***TOTAL:$_____***

☐ My child is age **13 or Older**, for ☐ **$65.00 - Full dental cleaning, Review** ☐ **Fluoride treatment $15.00** ☐ **Sealants $20.00** ***per tooth*** ***TOTAL:$_____***

☐ My child is age **1-21**, for ☐ **$30.00 - Review** of proper brushing, flossing and fluoride treatment. ☐ **Sealants $20.00** ***per tooth*** ***TOTAL:$_____***

MEDICAL/DENTAL HISTORY: **Has your child ever needed Antibiotics for dental treatment?** Y N ***if yes, please take the same precautions prior to treatment***

Please list dental concerns you may have:_____ List any Medical Conditions/Allergies your child has:_____

List ALL Medications:_____Physicians Name:_____

Has your child ever seen a Dentist? Y N Does your child take prescription Fluoride Supplements? Y N Do you have Town/City Drinking Water? Y N

Has he/she had a cleaning **in the past 6 months**? Y N If yes, was it at school? Y N Patient was last seen (*month & year*):_____

Patient last seen by (*if NOT last seen at school*):_____ Services received during **Last Visit**: *Cleaning—Fluoride—Sealant—Fillings—Exam—X-Ray Other:*_____

Dental Services you DO NOT want your child to receive from Tooth Protectors Inc. please list:_____

I give permission for my child to receive dental hygiene services **TWO (2) TIMES DURING THIS SCHOOL YEAR. (**if my child's school is able to offer it two times this school year.) I understand that I will receive **a reminder of the 2nd dental clinic date from the school and/or TPI and that my child will be automatically added to the dental clinic list to be seen**. It is my responsibility to notify either TPI (207) 513-1111 or my child's school prior to the 2nd dental clinic spring date to make any changes regarding my child's medical/dental history or removing them from the spring dental clinic list. I understand that the services provided today do not take the place of a complete dental exam by a dentist. However, dental services are being provided by a registered, licensed dental hygienist with Public Health Status (PHS) associated with Tooth Protectors Inc. (TPI), at school, during school hours. I have entered my child's information on this permission/consent form accurately and truthfully and understand that it is my responsibility to report/remember my child's date of dental service. I am also responsible to report this date when needed for current/future dental treatment and cannot hold TPI responsible if the information is not accurate/truthful on this form regarding current and/or previous treatment/appointments with other dental office locations. I agree to notify my child's school and/or TPI at (207) 513-1111 of ANY changes to my child's medical/dental history or of a dental home. I give permission for TPI to release patient and dental service information to benefit my child. I understand that services provided do not take the place of a complete exam by a dentist. I understand that TPI is HIPAA compliant and all records are kept confidential and that claims to insurance (if applies to your child) will go through TPI per electronic transfer or mail. Services not paid for by my insurance are my responsibility. I understand that if I have listed insurance information for my child & he/she does NOT have dental coverage at the time services are provided, **and/or** received the same services by another dental provider within 6 months and I did not divulged this above, than I assume all responsibility for payment of services received and understand that I will receive a bill from Tooth Protectors Inc.

_____ _____ _____

Parent/Guardian Signature **Parent/Guardian Printed Name** **Date**