School Dental Hygiene Program Permission Form 2019-2020 School Year

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

PLEASE FILL OUT IF YOU WANT YOUR CHILD SEEN

THIS FORM PROVIDES PERMISSION FOR YOUR CHILD TO BE SEEN TWO TIMES DURING THIS SCHOOL YEAR FOR DENTAL CARE.

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

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

Mailing Address:_____Town:_____ Zip Code:_____

Home Phone:_____ Cell: _____ Does the phone take texts? Y N Email:_____

DENTAL SERVICES: ***Please check ALL services you would like your child to receive – fees are for non-insured patients only***

____ All services that are covered by my insurance are requested OR I want only the services marked below (check all that apply):

____ Dental cleaning (AGE 1-12= $55) (AGE 13 and over $65) **_____ Fluoride $15** **____ Preventative Tooth Sealants $20.00 PER TOOTH**

____ Education Review ONLY $15

NOTE: Educational review is covered by MaineCare but not by commercial insurance. If you do not have MaineCare there is a $15 fee.

Dental Services you DO NOT want your child to receive from Tooth Protectors Inc: ___ Fluoride ___ Sealants ____**NO SERVICES REQUESTED**

INSURANCE COVERAGE: We currently DO NOT accept: Harvard Pilgram, Humana, Martins Point -Accepted insurance is subject to change without notice

___ MAINECARE INSURANCE- ID # for Child: _____A

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

Group #_____ Policy/Subscriber ID or:_____ Payer ID: _____ Dental Ins. Phone #: _____
Social Security # *(on back of Ins Card)*

Please SEND A COPY OF YOUR INSURANCE CARD front & back to: FAX: (207) 513-1197, EMAIL: Info@ToothProtectors.org, TEXT: (207) 402-8038

SELF PAY METHOD:

☐ Check or ☐ Money Order -attach to this COMPLETED permission form and return form & payment to your child's School - Check Number_____

Please make Check/Money order payable to: Tooth Protectors - Please write your child's Full Name in the Memo Line

There will be a $25.00 fee for insufficient funds

☐ Cash – must be in exact amount ☐ Credit Card (add $3.00 service fee) -Please call our office at 207-513-1111 prior to the clinic date

_____Please call me with total sealants needed and fee day of clinic, I will pay via credit card ***Please total services requested*** ***TOTAL: $_____***

Former MaineCare insured patients please read fully: "I understand, that my child no longer has active MaineCare coverage. I understand that I will be paying out of pocket and by signing this permission form, I understand that I am responsible for payment of services rendered"

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 Allergies your child has: _____

Does your child have any of the following (circle all that apply): Hemophilia Asthma Diabetes Autism Cancer Anxiety Other:_____

List ALL Medications:_____ Fluoride Supplements? Y N Does your child have a Dentist? Y N

Had a cleaning **in the past 6 months**? Y N Patient was last seen (*month & year*):_____ Patient last seen by: _____

Services received during **Last Visit**: *Cleaning—Fluoride—Sealant—Fillings—Exam—X-Ray ---Extraction---Braces---Space Maintainer--* Does your child have a history of cavities? Y N

Does your child Brush/floss at least 2 x Daily? Y N Does your child consume sugary products regularly? Y N Does your child use a fluoride Rinse? Y N

I give permission for my child to receive dental hygiene services **TWO (2) TIMES DURING THIS SCHOOL YEAR. (**if my child's school can 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**