MUST BE FULLY READ AND COMPLETED. INCOMPLETE FORMS CANNOT BE CONSIDERED FOR SERVICE.

DENTAL HYGIENE SERVICES: DENTAL PROPHY (CLEANING) UPLOADED Pt #_____
2019-2020
DENTAL HYGIENE SCREENING
DENTAL IMAGING (X-RAYS, INTRA-ORAL PHOTOS, ETC.)
FLUORIDE APPLICATION *
SILVER DIAMINE FLUORIDE*
TEMPORARY FILLINGS (FLUORIDE RELEASING)
PREVENTIVE DENTAL SEALANTS (CONTAIN FLUORIDE)
ORAL HYGIENE INSTRUCTION (INDIVIDUAL)
EDUCATION ON DIETARY RISKS FOR DECAY AND REFERRALS

DOES YOUR CHILD HAVE A REGULAR DENTIST? **YES **NO** IF YES, DATE SEEN:_____/_____/_____

HAS YOUR CHILD BEEN SEEN FOR CARE WITHIN THE PAST 12 MONTHS? **YES **NO**

****IF YOU ANSWERED YES TO BOTH QUESTIONS OR HAVE DENTAL INSURANCE THAT IS NOT MAINECARE THEN YOU DO NOT QUALIFY FOR THIS SERVICE AND SHOULD NOT COMPLETE THIS FORM****

STUDENT NAME:_____DOB:_____(MALE/FEMALE Optional)

ADDRESS:_____ZIP:_____

SCHOOL:_____GRADE:_____TEACHER:_____

MAINECARE: ID#____/____/____/____/____/____/____/____/____ QUALIFY FOR FREE/REDUCED LUNCH? YES / NO

MEDICAL: PHYSICIAN/OFFICE:_____PHONE:_____

LIST ALL MEDICAL CONDITIONS: HEART PROBLEMS SEIZURES DIABETES KIDNEY DISEASE ASTHMA ADD/ADHD

OTHER:_____

LIST ALL MEDICATION:_____LIST ANY SURGERY:_____

LIST ALL ALLERGIES: IODINE SILVER MILK/DAIRY SEASONAL DYES LATEX NUTS EPI PEN? YES / NO
FOOD ALLERGY List:_____MEDICATION ALLERGY List:_____Others:_____

DOES THIS STUDENT REQUIRED ANTIBIOTIC PREMEDICATION BEFORE DENTAL TREATMENT? YES / NO

DOES THIS CHILD HAVE ANY MENTAL OR PHYSICAL DISABILITY REQUIRING ASSISTANCE? YES / NO
(IF YES: CIRLE/EXPLAIN) ONE ON ONE AID NURSE WHEELCHAIR OTHER:_____

SAVING SMILES OF MAINE PRIVACY PRACTICE: IN SIGNING , I AGREE THAT I HAVE READ THE SAVING SMILES OF MAINE GUIDELINES COMPREHENSIVELY DISCLOSED IN THEIR PRIVACY PRACTICE NOTICE MADE AVAILABLE AT WWW.SAVINGSMILESOFMAINE.ORG. I AM AWARE THAT THESE GUIDELINES ARE AVAILABLE THROUGH MY SCHOOL UPON MY REQUEST. I UNDERSTAND VIDEO SURVEILLANCE IS USED MONITORING STUDENT SAFETY.

CONSENT TO TREAT: IN SIGNING THIS FORM, I GRANT SAVING SMILES OF MAINE PERMISSION FOR ALL DENTAL HYGIENE SERVICES AVAILABLE TO BE RENDERED BY AN AUTHORIZED LICENSED DENTAL HYGIENIST AND/OR SENIOR UMA DENTAL HYGIENE STUDENTS UNDER DIRECT CLINICAL SUPERVISION DURING THIS ACADEMIC SCHOOL YEAR. I HAVE READ THE BACK PAGE OF THIS DOCUMENT CLEARLY EXPLAINING THE SERVICES LISTED ABOVE. I UNDERSTAND THAT SCHOOL BASED DENTAL HYGIENE DOES NOT TAKE THE PLACE OF A COMPREHENSIVE EXAMINATION BY A DENTIST. IF NECESSARY, PERMISSION IS GRANTED TO SAVING SMILES OF MAINE TO REQUEST OR RELEASE CONFIDENTIAL INFORMATION ON THE ABOVE-NAMED STUDENT FOR THE PURPOSE OF ASSESSING ELIGIBILITY, PERFORMING HEALTH ASSESSMENTS, PROVIDING CARE, IN ATTAINING REIMBURSEMENT, IN MAKING REFERRALS AND AS MANDATED FOR THE BENEFIT OF THE INDIVIDUAL. THIS APPLIES TO INFORMATION EXCHANGED TO AND FROM SCHOOL PERSONNEL, NURSES, MAINECARE, PHYSICIANS OFFICE, HEALTH FACILITIES, DENTISTS, AND DENTAL PRACTICES. (FOLD AND RETURN TO SCHOOL NURSE)

DATE:_____PARENT/GUARDIAN-PRINT:_____

SIGNATURE:_____PHONE:_____RELATIONSHIP:_____

SCHOOL NURSE:_____/__/___ _____/__/__