ORAL HEALTH SERVICES CONSENT FORM 2018-2019

Garden Place Academy/Elementary School Oral Health Screenings and Dental Services October 29, 30, November 1, 2, 2018

The American Academy of Pediatric Dentistry recommends that children have a fluoride varnish treatment up to **four (4)** times per year. Clínica Tepeyac (Tepeyac) has offered to provide preventive dental services to your child during school hours. The preventive services may include a cleaning, and/or brushing your child's teeth and apply fluoride varnish by a dental hygienist. They may take digital x-rays. They will decide if any back teeth are proper for sealants (the teeth will be painted with a plastic coating that will keep food and germs out of the grooves of the teeth). Clínica Tepeyac (Tepeyac) has offered to provide fluoride varnish treatment for your child this year in the fall and the Spring, as part of the Pediatric Care Program. This preventive care does not take the place of a regular dental checkup.

Signing this form will give consent to Tepeyac to provide up to **two (2)** fluoride varnish treatments during the 2018-2019 school year, one in the fall/winter and one in the spring. Signing this form authorizes Clinica Tepeyac to bill your Medicaid Health First Colorado or CHP+ insurance company for preventative dental services provided. If you do not have dental coverage, Clinica Tepeyac will provide these preventative dental services at no cost to the parent/legally authorized representative. In order to receive these preventative dental services at your child's school, the parent/legally authorized representative will need to sign the consent form and provide the registration information listed below.

☐ **YES**, I want my child to receive a dental screening, cleaning, fluoride varnish, digital x-rays and if needed dental sealants.

☐ **NO**, I do not want my child to receive a dental screening, cleaning, fluoride varnish, digital x-rays, or dental sealants.

Student Information (Print all information in ink)

Patient Student Full Name	First: Middle: Last:
Date of Birth	Month: Day: Year:
Patient Student Medicaid/Insurance Plan	Medicaid/Insurance Plan Name: Medicaid/ Plan ID#: ☐ No Insurance
Patient Sex	☐ Male ☐ Female
Home Address	
City/Zip Code	City: Zip:
Preferred Phone Number	( ) __ __ __ - __ __ __ __
Student's Main Language	☐ English ☐ Spanish ☐ Other
Guardian/Parent Name	First: Middle: Last:
Student Race	☐ American Indian/Alaskan Native ☐ White ☐ Asian ☐ Hispanic ☐ Native Hawaiian /Pacific Islander ☐ Unreported/Refused to Report ☐ Black/African American ☐ Other:
Student Ethnicity	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Refuse to Report
Does your child visit the dentist regularly and/or is your child under the care of a dentist? ☐ **Yes** ☐ **No**	
If under the care of a dentist, please provide Dentist name:_____ **Date of last dental visit:**_____	
Who is your child's primary care physician (PCP): _____	

Allergies

☐ Yes ☐ No Does your child have any allergies to food or medicine?
☐ Yes ☐ No Does your child have any allergies to pine nuts or colophony (colophonium)?
☐ Yes ☐ No Has your child ever had a reaction to latex?
☐ Yes ☐ No Does your child have any heart problems?

Sliding Fee Scale (Optional)

Clinica Tepeyac has a sliding fee scale for those patients who do not have insurance. If you would like to be considered for Clinica Tepeyac's sliding fee scale, please provide us with your income and family size below. If eligible for Clinica Tepeyac's Sliding Fee Scale, you will be given the discount for a 12-month period. The Sliding Fee Scale will be valid for any services received from Clinica Tepeyac over the next 12 months.

☐ **Refuse to Report Family Size and Income.**

Family Size	
Yearly Family Gross Income	

Consent for Oral Health Services/Treatment

I understand that I will be notified of any services my child receives, as well as any abnormal findings and/or further treatment recommendations. I give permission for my child to get a dental screening, cleaning, sealants, x-rays, and fluoride varnish at the school site. I also understand I should contact the school nurse if I have questions about any necessary follow-up care or instructions. I understand this consent will remain valid throughout the 2018-2019, 12- month academic year unless revoked by me. **I may revoke this consent for treatment at any time by requesting in writing to remove my child from receiving oral health screenings/services.** It is my responsibility to notify the school nurse of all updates or changes to my child's health condition(s), immunization records, medications or insurance coverage. I realize I can take my child to another dentist at any time. **I understand that these dental services are preventative treatments, and cavities can still form without adequate oral hygiene and routine care.** Dental care will be performed by a Tepeyac's hygienist.

My signature below indicates that I have reviewed, understand the information, and agree to the terms and conditions outlined.

Grade: _____Teacher: _____

Guardian Print Name:_____ Guardian Signature: _____ Date:_____