Oral Health Screening and Fluoride Varnish Program Consent

Fall 2022

Tooth decay is one of the most common **preventable** diseases in children. Dental disease can be painful and can occur in very young children. Close to 4 out of 10 children have cavities by the time they enter kindergarten. With regular checkups and preventive measures early in a child's life, many of these problems can be prevented.

For this reason Lake George Charter School has teamed up with Mountain Dental Hygiene Services LLC and High Mountain Hygiene PC to offer an oral **preventive** program for its children. Every few months your child will be screened and cleaned by a registered dental hygienist using a mirror and light for early signs of oral disease. If any problems are found, you will be referred to a dentist for further evaluation. We will also do a **fluoride varnish** during the screening. It is recommended that children have this at least 2-3 times a **year.** Parents are welcome to be there with your child during the screenings.

I have read and understand the information given to me regarding the Oral Screening and Fluoride Varnish program. I give consent for my child to receive oral screening, cleaning education, and fluoride varnish as part of this program. I also give consent for information to be shared with the Health Department, Medicaid, and other agencies as may be required to evaluate the effectiveness of this program. I understand that I have the right to ask and have answered additional questions that may arise during the course of this program of treatment. I understand that there are no guarantees regarding any treatment results. If no insurance, the cost is $65.00.

Child's Name ____ Date of Birth ____________________

Parent/Guardian Signature ____ Date ____________________

Please Print:
Parent Name: ____ Date of Birth ____________________

Address/including Zip: ____

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Phone number: _____________________________________ Cell Ph. number: ______________________

Has your child ever seen a dentist? YES NO If so, dentist's name ___________________________

Month/Year of last dental visit _____________________________________

Insurance Information: If your child has Medicaid or CHP+, their participation in this program is encouraged because it helps keep them healthy and prevent unnecessary pain from cavities and costs for their treatment. Please provide their information below for record keeping/billing purposes.

MEDICAID
Medicaid Number __________________

OTHER INS. ___________________
ID# ____________________________
Group# ________________________

CHP+
CHP+ Number ________________________

SSN _______________________ (required for CHP + billing)