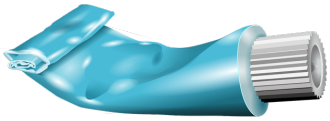
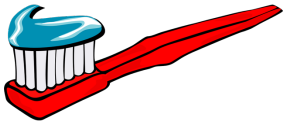
TRI-COUNTY DENTAL
A community clinic of volunteers serving in an atmosphere of kindness, compassion & respect

ROBERT GLASS FOCUS ON THE CHILDREN PROGRAM

# FREE DENTAL CARE

## PROGRAM FOR YOUR CHILD



If your **preschool, kindergarten and/or elementary school child**

- is eligible for free or reduced cost hot lunch
- or has a ForwardHealth card from Medicaid (BadgerCare)
- *and* **DOES NOT** have private dental insurance

they can receive **free** dental care.

Complete the attached forms and return them to your child's school and your child will be seen throughout the school year for routine dental care.

*If you have any questions, PLEASE contact Lisa or Nkaoxue at Tri County Dental @920-882-5500 for additional information.*

*See the back of this sheet for specific program information

# Dental Program Process

## Phase 1 Takes place in your child's school

(Or at clinic, a chaperoned school bus will transport children to and from the clinic)

- ✓ Dental hygienist will:
  - Clean your child's teeth and record the student's general oral health
  - Contact a parent/guardian with notification of urgent needs
  - Apply fluoride varnish (a mineral proven to reduce cavities), sealant or SDF (Silver Diamine Fluoride) as appropriate

## Phase 2 Takes place on the Mobile Dental Clinic at your child's school

- ✓ Dental Hygienist or Dental Assistant will:
  - Take x-rays
  - Place sealants, if appropriate
  - Apply fluoride varnish and Silver Diamine Fluoride (if necessary)
- ✓ Children will receive oral health education
- ✓ A Dentist will do a thorough examination of your child's teeth, preparing a treatment plan if your child requires fillings and/or other dental work
  - ✓ *Children requiring additional treatment will need Phase 3*

## Phase 3 Takes place on the Mobile Dental Clinic at your child's school or at Tri-County Dental Clinic

(For clinic visits, a chaperoned school bus will transport children to and from the clinic)

- ✓ A dentist will provide the necessary restorative work your child requires

  (You will be notified before your child is seen for fillings and consent must be obtained by you before any tooth extraction.)

- ✓ Parent/guardian is encouraged to call our clinic for restorative needs

  (Please know that dental problems will not go away on their own, so please contact us as soon as possible to schedule follow-up care.)

  **920-882-5500**

For Office Use Only:

Chart #:_____

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# DENTAL CONSENT FORM

Dear Parent,

Tri-County Dental is offering an oral health program for children in your elementary school. The program includes a dental cleaning, an exam, x-rays, fillings, fluoride treatments and oral health education. A new toothbrush, toothpaste, and floss will be sent home with your child. Please complete this form if you want your child to be part of the program:

**Child's Last Name**: _____ **Child's First Name**: _____

**Child's Date of Birth**: _____-_____-_____ **Female / Male** **Phone Number** (_____) _____-_____

**Child's Address**: _____ **Zip Code**: _____

**School**: _____ **City:** _____

**Homeroom Teacher**: _____ **Grade (circle)**: EC/PK K 1 2 3 4 5 6

- Does your child have private dental insurance? **YES / NO** – if YES, your child may only be seen for fluoride treatment
  Name of Dental Insurance Company: _____
- Does your child see a dentist on a regular basis (every 6 months)? **YES / NO**
- Does your child have allergies to Colophony resin? **YES / NO**
- Does your child have Medicaid (Medical Assistance, Badger Care, Title 19)? **YES / NO**
  **Medicaid Number (Member ID)** _____

Child's Race/Ethnicity (Check all that apply): _____White _____African American/Black _____Asian
_____Hispanic _____American Indian / Alaska Native _____Native Hawaiian / Pacific Islander _____Other

I understand the nature of the treatment provided and authorize Tri-County Dental staff to provide oral health treatment.

- I acknowledge that Tri-County Dental may use my child's information for treatment and may disclose it to my insurance company and/or other health care providers even though it may affect future insurance claims.
- I understand that this registration is effective for a period of **thirteen months** to provide follow-up services, including restorative treatment, dental cleaning, application of sealants and multiple fluoride applications which may include silver diamine fluoride SDF is an antibiotic liquid and helps slow further decay; will cause staining to the treated lesion and potential staining of skin and clothes; will not stain a healthy tooth; is a treatment for cavities but not a cure, so additional restorative care may be needed; reapplication for disease control may be needed. Please inform Tri-County Dental if child has a silver allergy or is unable to have fluoride.
- I understand that my child's restorative treatment plan, if necessary, will be provided to me prior to the treatment starting.
- I am authorizing Tri-County Dental to use nitrous oxide if needed for the completion of dental treatment.
- I agree to the release of my child's treatment plan records so I can receive them from the school.
- I am specifically authorizing the clinic to treat my child whether I am physically present at the clinic during a scheduled treatment.

My signature will confirm my informed consent, my status as the legal custodian of the minor patient identified and my authority to grant this consent. I understand that I may contact Tri-County Dental at 920.882.5500 with any questions.

_____/_____ ____/____/_____

**(Print) parent/guardian** **(Signature) parent/guardian** **Date**

# Medical History

For the following medical history questions, **please (x) whichever applies**. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your child's health. This information is vital to allow us to provide appropriate care for your child. This clinic does not use this information to discriminate.

**Child's Name**: _____ **WE CANNOT SEE YOUR CHILD IF THIS IS NOT COMPLETE!**

**Please check yes, no, or unsure if your child has/had any of the following conditions:**

| Yes | No | Unsure | | Yes | No | Unsure | | Yes | No | Unsure | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | Allergies (list below) | ☐ | ☐ | ☐ | Hepatitis | ☐ | ☐ | ☐ | Tumors |
| ☐ | ☐ | ☐ | Anemia | ☐ | ☐ | ☐ | Herpes | ☐ | ☐ | ☐ | Radiation Treatment |
| ☐ | ☐ | ☐ | Asthma | ☐ | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | ☐ | Chronic Ear Infections |
| ☐ | ☐ | ☐ | Autism | ☐ | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | ☐ | Pregnant (at this time) |
| ☐ | ☐ | ☐ | ADHD/ADD | ☐ | ☐ | ☐ | Hyperactivity | ☐ | ☐ | ☐ | Sexually Transmitted Diseases |
| ☐ | ☐ | ☐ | Birth Defects | ☐ | ☐ | ☐ | Kidney Disease | ☐ | ☐ | ☐ | Hearing Loss/Impairment |
| ☐ | ☐ | ☐ | Bleeding Problems | ☐ | ☐ | ☐ | Learning Disabilities | | | | |
| ☐ | ☐ | ☐ | Blood Disorders | ☐ | ☐ | ☐ | Liver Disease | ☐ | ☐ | ☐ | Heart Conditions/Murmur |
| ☐ | ☐ | ☐ | Cancer | ☐ | ☐ | ☐ | Mental Disability | ☐ | ☐ | ☐ | If yes to heart murmur, is an antibiotic |
| ☐ | ☐ | ☐ | Cerebral Palsy | ☐ | ☐ | ☐ | Muscular Dystrophy | | | | required before dental appointments**? If you are** |
| ☐ | ☐ | ☐ | Developmental Delay | ☐ | ☐ | ☐ | Psychiatric Problems | | | | **unsure, we will need confirmation from your** |
| ☐ | ☐ | ☐ | Diabetes | ☐ | ☐ | ☐ | Rheumatic Fever | | | | **cardiologist before treatment.** |
| ☐ | ☐ | ☐ | Downs Syndrome | ☐ | ☐ | ☐ | Seizures | | | | |
| ☐ | ☐ | ☐ | Emotional Problems | ☐ | ☐ | ☐ | Sickle Cell Anemia | ☐ | ☐ | ☐ | Jaundice (not at birth) |
| ☐ | ☐ | ☐ | Epilepsy | ☐ | ☐ | ☐ | Skin Disorders | ☐ | ☐ | ☐ | Delayed Speech Development |
| ☐ | ☐ | ☐ | Fainting Spells | ☐ | ☐ | ☐ | Tuberculosis | | | | |

Please explain all "Yes" or "Unsure" responses:

Please list any other problems/conditions/allergies your child may have

## Current Medication List

Is your child taking any prescription medications, over the counter medications, vitamins, natural and/or herbal dietary supplements? ☐ Yes ☐ No If yes, please list medications.

| Medication | Reason for Taking | How Much | How Often |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

To the best of my knowledge, the indicated health history remains current. I understand that any change in the patient's health or medication requires that an updated form be completed. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I certify that I have read and understand the above.
I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____/_____ Date____/____/_____
(Print) parent/guardian (Signature) parent/guardian

## Emergency Contact Information:

Name: _____ Relationship: _____

Emergency Number: _____

For Office Use Only:

Chart #:_____

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# PHOTO / INTERVIEW RELEASE

Date: _____

I, _____, hereby give the Tri-County Community Dental Clinic, its staff, representatives, community partners, and legal representatives (in connection with dental services which I am receiving) and irrevocably agree and consent to allow photographs and or information from interviews to be used as part of the dental record, research, education, public relations, patient counseling, or other purposes.

Consent:_____
*Signature*

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