**Maine Dental Health Out-Reach, Inc.**

**Tooth Angel Program**

**2019-2020 Dental Consent Form**

**Dental Hygiene Services**: screening, x-rays, prophylaxis (dental cleaning), fluoride application, sealants, temporary fillings, antimicrobial liquid silver diamine fluoride, oral hygiene instruction, re-mineralization application & referrals to outside care

**Dentist Services (when available at school):** exam, local anesthesia (to numb up the tooth and gum), restorative care (included but not limited to) fillings, stainless steel crowns on baby molars, pulpotomys (nerve treatment), extractions of infected non-savable teeth and extraction of over retained baby teeth (baby teeth that will not come out on their own)

**Student’s Name:** Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Town\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_­­­\_\_\_

**Student’s Date of Birth:** \_\_\_\_\_\_ / \_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_\_ **Male Female**

**Parent/Guardian Phone:** 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ home / cell 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ home / cell / work

**School**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Teacher**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Grade** \_\_\_\_\_\_\_

**PAYMENT OPTIONS:**

**Student’s MaineCare Number:** \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ **A**

**Traditional Dental Insurance**: Staple a photocopy of the front and back of the insurance card to this form. If not attached, MDHO will be unable to process this form.

**Cash Payer**: Staple a check to this form, payable to MDHO for the Dental Hygiene Services listed above **Fee:** $145.00

**MEDICAL INFORMATION:**

**Circle medical diagnosis:** ADD, ADHD, Anxiety**,** Autism, Bleeding Disorders , Cancer, Depression, Diabetes, Heart Problems Kidney Disease, Liver Disease, Oppositional Defiant Disorder or Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List allergies**: dairy (milk casein), dye, environmental, food, gluten, latex, medication, or other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Epi-Pen at school**? Yes **/** No **Does your child require ANTIBIOTICS prior to dental procedures?** Yes / No

**Last Dental Appt.:** **Month** \_\_\_\_\_ **Year** \_\_\_\_\_ **By Whom**: Tooth Angel Program (us) Other (name)\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Concerns?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Has your child been dismissed from the above practice?** Yes / No

**Consent:** By signing this document, you are giving MDHO, Inc. permission to treat your child for the above services and you confirm that you have read MDHO’s Policy Disclosures and the Dental Consent to Treat Statement, as described on the back side of this paper.

**Parent/Guardian Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Consent to Treat Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MDHO, Inc. HIPAA Policy Disclosure:** This personal information will not be shared with anyone other than the person listed on the “Parent/Guardian Consent to Treat” (page 1), without a HIPAA request form. If you would like a copy of MDHO, Inc.’s HIPAA Policy, you may obtain one from the school nurse or download it from our website: [www.mdhoi.org](http://www.mdhoi.org)

**Dental Consent from Parent/Guardian to Treat Statement:** I give MDHO, Inc. permission for this child to receive dental hygiene services by a MDHO, Inc. public health dental hygienist. I understand that the dental hygiene services that will be received do not take the place of an examination by a dentist.

I also give permission for my child to be treated when a MDHO, Inc dentist is in the van, at their school. I understand that a referral will be sent home if the MDHO, Inc. dentist is unable to complete all of the dental work my child needs.

Permission is also granted to obtain necessary, confidential information needed, from the people listed below, in order for my child to receive dental hygiene services.

This includes information needed from/to the following: 1. The school nurse 2. The school staff (if there is no nurse available) 3. The previous dentist 4. The dentist MDHO, Inc. is referring this child to.

I also give permission for MDHO, Inc. to share information provided on the consent form with the school nurse.

I understand it is my responsibility to contact MDHO, Inc. @ 377-7003, if my child has a dental appointment in another office prior to being seen at school, and I understand that if my child does not qualify for these services, the parent/guardian will not be contacted and the consent form will be shredded.

**MaineCare Temporary Filling Policy:** “It is very important that you understand that this is not a permanent fix to the dental problem your child has. You need to take your child to a dentist for the proper care. If your child does not see a dentist, their condition could get worse.“

**Photo Consent:** By signing below, I give permission for MDHO, Inc. to take a photo of my child. I understand this photo may be used on their website (www.mdhoi.org), in grant applications and reports, in the MDHO, Inc. brochure, as well as, other media purposes to promote the services that MDHO, Inc. provides.

 **Parent/Guardian Photo Consent Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

