



640 West Highway 92, Suite 3
Williamsburg, KY 40769
Phone: (606) 765-6080 Fax: (606) 371-5335
www.dayspringdental.org

SCHOOL DENTAL - INTRODUCTION

DEAR PARENT/GUARDIAN,

Dayspring Dental is excited to partner with your school and Elgin Children's Foundation to provide quality, compassionate dental care to students of Whitley County! This means children can receive their regular dental exam, cleaning, fluoride application, and sealants in the comfortable and familiar surroundings of their school. Below is an explanation of services we plan to provide:

- Cleaning – removes all hard and soft material that forms on teeth.
- Fluoride Varnish – applied to teeth to strengthen them and prevent/arrest decay.
- Sealants – a thin resin placed on permanent molars (back teeth) to prevent decay.

Our program uses the latest technology in portable equipment, allowing us to set up a dental clinic in any classroom. This creates convenient access to dental care and reduces missed instruction time for dental appointments.

Students needing further dental treatment (fillings, crowns, etc.) can be transported by bus, during school hours, to our dental clinic across from Walmart in Williamsburg. Each participating student will receive a gift pack that includes a new toothbrush and toothpaste!

All students will also be provided a free dental screening at the beginning of the school year. Our dental staff will simply look at your child's teeth using a light. This "look" is not intended to take the place of your child's regular dental visit. After the screening is completed, you will receive a copy of your child's dental results and the dentist's recommendations for your child. To better understand this procedure, please visit our website (www.dayspringdental.org) to watch a video demonstrating a dental screening. If you prefer your child does not participate in these oral health screenings, please send a written note to your child's teacher by November 6, 2020.

Please complete and return the School Dental - Registration and Consent Forms to indicate what level of services you wish your child to participate in for the coming school year.

Our goal is to keep kids healthy and keep them learning as much as possible! We sincerely appreciate the opportunity to serve your child and serve our great community.

Sincerely,
Dayspring Dental Staff



DENTAL CONSENT AND AUTHORIZATION (EFFECTIVE FOR 1 YEAR)

1 – DENTAL SERVICES: INITIAL THE TYPE OF DENTAL SERVICES YOU WISH YOUR CHILD TO RECEIVE (ONLY ONE)

- _____ **ALL DENTAL SERVICES** – I give permission for my child to receive comprehensive dental care by Dayspring Dental providers and staff. I understand this includes a comprehensive exam, cleaning, fluoride varnish application, sealants, and routine x-rays (if indicated) performed at school.
- If further treatment is deemed necessary, I give permission for my child to be transported by school bus to Dayspring Dental at 640 W. Hwy 92, Suite 3 Williamsburg, KY 40769.
 - I give Dayspring Dental permission to treat my child’s needs by using, but not limited to: amalgams (silver fillings), composites (tooth colored fillings), porcelain or stainless-steel crowns, and fluoride.
 - I give Dayspring Dental permission to perform, if needed but not limited to: dental x-rays, oral surgery including extraction (removal of 1 or more teeth), root canal therapy, pulpal therapy, space maintainer placement, silver diamine fluoride therapy, or any other treatment associated with provision of dental care.
 - I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the dentists. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.
 - I understand that nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. All dental services will be provided during regular school hours.
- _____ **PREVENTIVE DENTAL SERVICES AT SCHOOL ONLY** – I give permission for my child to receive preventive dental care by Dayspring Dental providers and staff. I understand this includes a comprehensive exam, cleaning, fluoride varnish application, sealants, and routine x-rays (if indicated) performed at school during regular school hours.
- I do not wish for my child to be transported to Dayspring Dental for any further dental treatment, if needed.
- _____ **NO DENTAL SERVICES** – I do NOT wish for my child to receive any dental treatment during regular school hours. My child is already in the care of a dentist. *If you choose this option, do not complete registration packet.

****To best address the health needs of our students, Dayspring Dental will **provide free dental screenings for ALL students**. The screenings will be conducted during the school year. After the screening is completed, you will receive a copy of your child’s dental results and the dentist’s recommendations for your child. If you prefer your child does not participate in these oral health screenings, please send a written note to your child’s teacher by November 6th, 2020.*

#2 – CONSENT FOR BILLING AND HIPPA

I certify the above information and registration packet are correct. I authorize Dayspring Health to bill my insurance for services rendered and authorize the release of medical information to my insurers. I understand that if my insurance or other benefits do not cover the services my child receive, I am responsible for payment of the account. I authorize payment of medical benefits by my insurance to Dayspring Health. I have received and understand the Notice of Privacy, Patient Rights and Responsibility, and Title VI, which are available online and in paper form at the office.

_____	_____	_____
Print Child’s Name	Date of Birth	Today’s Date
_____	_____	_____
Print Parent or Legal Guardian’s Name	Signature(parent/guardian)	Relationship

#3 – RETURN TO CHILD’S TEACHER WITH COMPLETED REGISTRATION PACKET!!!



SCHOOL HEALTH - REGISTRATION AND CONSENT 2020-2021

STUDENT'S PERSONAL INFORMATION

Please PRINT and complete ALL sections below!

Name (Last) _____ (First) _____ (Middle Initial) _____

Date of Birth ____ / ____ / ____ Social Security # ____ - ____ - ____

Address _____ Apt # ____ City _____ State ____ Zip _____

Email _____ School Name _____ Grade _____

CONTACT INFORMATION

I authorize Dayspring to use the following numbers for voice mail, text, or email:

Cell Phone (____) _____ Home Phone (____) _____ Work Phone (____) _____

Preferred Contact Method (circle): Phone Text Email I do not want voice, text, or email messages.

GENERAL STUDENT INFORMATION

Race:
 White
 Black/African American
 American Indian / Alaskan
 Asian
 Other _____

Gender:
 Male Female
 Choose Not To Disclose

Ethnicity:
 Non-Hispanic
 Hispanic/ Latino
 Refused to Report/ Unreported

What language do you speak?
 English
 Spanish
 Other _____

Do you live in public housing?
 No
 Yes

RESPONSIBLE PARTY FOR INSURANCE

Relationship to Student: Parent Other: _____

Name (Last) _____ (First) _____ (Middle Initial) _____

Date of Birth ____ / ____ / ____ Social Security # ____ - ____ - ____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

DENTAL INSURANCE (STUDENT'S)

What kind of Dental Insurance do you have? Do NOT have **Dental** Insurance

Name of Insurance _____ ID# _____

PO Box _____ City _____ State _____

HEALTH INSURANCE (STUDENT'S)

What kind of Health Insurance do you have? Do NOT have **Health** Insurance

Name of Insurance _____ ID# _____

PO Box _____ City _____ State _____

SLIDING FEE

Dayspring provides help with dental/medical payments for non or under-insured patients. .

Please check if you... would like more information about Dayspring's assistance program (Sliding Fee).
 decline information about Dayspring's assistance program (Sliding Fee).



SCHOOL HEALTH - REGISTRATION AND CONSENT 2020-2021

STUDENT'S NAME	Last _____ First _____
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PRIMARY CARE PROVIDER (PCP)	Provider _____ City _____
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PRIMARY DENTIST	Dentist _____ City _____
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PREFERRED PHARMACY	Pharmacy _____ City _____
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MEDICAL HISTORY	Please PRINT and complete ALL Sections below!		
Medical History: <input type="checkbox"/> Asthma <input type="checkbox"/> ADHD <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy (Seizures)	<input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Kidney Disease	Medical History (Continued): <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Surgical History: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

MEDICATIONS	Please include ALL prescribed medications and their doses. *Very important.

ALLERGIES	Please include all allergies to medications, food, and environment.	
<input type="checkbox"/> Ibuprofen <input type="checkbox"/> Tylenol <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin/Amoxicillin <input type="checkbox"/> Clindamycin <input type="checkbox"/> Anesthetics (Lidocaine) <input type="checkbox"/> Latex	<input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____

DENTAL HISTORY	Please complete to the best of your knowledge regarding your child.
Check all that apply: <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Special needs <input type="checkbox"/> Chemo/radiation treatment <input type="checkbox"/> High sugar diet <input type="checkbox"/> Eating disorder <input type="checkbox"/> Poor family dental health <input type="checkbox"/> Pre-med required	Please circle appropriate answer: <i>Frequency of routine dental visits:</i> None Irregular Every 6 months <i>Times per day teeth are brushed:</i> None Once/day Twice or more/day <i>Child uses floss:</i> NO YES <i>Child uses fluoridated toothpaste:</i> NO YES

CONSENT TO RELEASE HEALTH RECORDS	I authorize permission to release dental/medical information to:
Name: _____	Relationship: _____
Name: _____	Relationship: _____

EMERGENCY CONTACT	Please list at least one contact.
Name: _____	Phone: _____ Relationship: _____
Name: _____	Phone: _____ Relationship: _____