Optional-Dental-Prevention Works 2024-2025

IF YOU DO NOT WANT YOUR CHILD TO PARTICIPATE OR THEY ALREADY HAVE A DENTIST-DO NOT FILL OUT THIS FORM.

A Dental Hygienist will see your child during school hours (twice per year) to provide: oral screening, dental cleaning, fluoride varnish, oral hygiene instructions, sealants, temporary fillings and/or Silver Fluoride (SF.) SF is used to temporarily manage cavities until your child is able to see a dentist for permanent fillings. When cavities are treated with SF, the tooth will turn dark, which is a good indication that the infection in the tooth is dying. If you DO NOT want SF used, please check this box ☐ IF YOU WANT YOUR CHILD TO BE SEEN-THE ENTIRE FORM MUST BE COMPLETED OR IT WILL BE RETURNED TO YOU TO COMPLETE. THIS PROGRAM DOES NOT REPLACE AN EXAM BY A DENTIST.

FULL NAME OF STUDENT- PLEASE PRINT CLEARLY:_____GENDER:_____

DATE OF BIRTH:_____-_____-_____ SCHOOL:_____GRADE:_____

PARENT/GUARDIAN INFORMATION:

PARENT/GUARDIAN NAME:

ADDRESS:

PHONE NUMBER: EMERGENCY #:

PLEASE PROVIDE THE REQUESTED INFORMATION BELOW, AS IT MAY BE NEEDED IN CASE OF EMERGENCY. IF THERE ARE NONE-PLEASE PUT N/A

MEDICAL CONDITIONS: _____
CURRENT MEDICATIONS: _____
ALLERGIES: _____

Do you have any dental questions/concerns?_____
Has your child seen a dentist or hygienist? Yes___ No___ Date of last visit:_____
Dentist's Name or location of last visit: _____

IF YOU WOULD LIKE TO BE SELF PAY-you will be contacted by Prevention Works before your child's visit to discuss services, cost, payment procedure.

☐ 12 or younger-$55 (includes cleaning & fluoride varnish)
☐ 13 or older-$65 ((includes cleaning & fluoride varnish)
☐ Sealants- $20 per tooth (usually recommend on 6 and 12 year molar teeth)

WE WILL ACCEPT THE FOLLOWING DENTAL INSURANCE: MAINECARE, DELTA DENTAL, UNITED HEALTHCARE, CIGNA, AND PATIENTS ADVOCATES.

PLEASE FILL OUT INSURANCE SECTION ENTIRELY. A COPY OF BOTH SIDES OF THE INSURANCE CARD IS HELPFUL.

DENTAL INSURANCE: *PLEASE PRINT CLEARLY*

Company Name:_____**Policy/ ID #**_____**Group:**_____

Subscriber's Name_____**Subscriber's date of birth**____/____/_____

Subscriber's Address_____

Insurance company provider line phone number:_____

I hereby give permission for my child to be seen throughout the school year. I understand that Prevention Works is HIPPA compliant and all records are kept confidential and that claims to MaineCare insurance will be electronically transferred. ***By signing below, you are giving Prevention Works authorization to share medical/dental information with other healthcare professionals.***

PARENT/GUARDIAN SIGNATURE:_____**DATE:**_____