610-969-4839
484-788-9678

No Cost, High Quality Dental Care for Your Child

The ***Miles of Smiles*** **mobile dental unit** is coming to your child's school!

Dental Exams and Treatment are available to children in Kindergarten through 12th Grade.

If your child qualifies and you wish to have your child in the care of our dental office, please complete both forms and **sign in ink.**

We accept:

✓Pennsylvania Medical Assistance (Medicaid) and eligible CHIP plans:

- PA Medicaid
- AmeriHealth Caritas
- Highmark Wholecare Medicaid
- UPMC Kids/UPMC for You
- CHIP Plans (Highmark Blue Shield Kids)
- United Healthcare Families Medicaid
- United Healthcare for Kids Community Plan
- Aetna Better Health Kids
- Geisinger and Health Partners
- KidzPartners

✓ Students with no dental insurance

Children should not currently be receiving dental care at any other facility, with the exception of the Lehigh Valley Hospital – 17th Street Dental Clinic.

Lehigh Valley Health Network
Lehigh Valley Mobile Dental Van

CONSENT FOR ROUTINE DENTAL TREATMENT

I understand that this *Consent* form and the *Patient Information and Health History* must be filled out and returned to the ***School Nurse*** before dental (tooth) care will be scheduled for my child. A dental treatment plan will be made for my child based on examination and diagnosis. Dental care will be given to my child at my request. A written report of the dental care given will be sent home with my child after each visit to the Lehigh Valley Mobile Dental Van.

I have received a copy of the Health Information Privacy Notice for Lehigh Valley Health Network.

I request and authorize the dental staff of Lehigh Valley Health Network to give any routine dental services that may be needed by my child after a routine dental examination on the Lehigh Valley Mobile Dental Van. Routine treatment will include an evaluation by a licensed dental professional and may include x-rays, cleaning, sealants, fluoride placed on teeth (topical fluoride), injection of a medication to numb the mouth, tongue, gums and teeth (local anesthesia) and/or fillings of the teeth. I understand that, if my child needs additional services, I must agree and consent to those services before they will be given.

I have been informed and understand that the risks of dental treatment are uncommon but can happen. These risks include:

- infection,
- continued numbness or tissue irritation from local anesthesia,
- breathing in or swallowing a foreign body,
- accidental cut,
- soreness,
- pain and
- swelling.

I understand that I must tell the dental staff of any changes in my child's health, medications or insurance coverage. I also understand that if I have any questions or concerns about the dental services or this consent, I should call the dental program coordinator at 610-969-4839 before I sign this consent form.

I authorize Lehigh Valley Mobile Dental Van to give my child's school a copy of the report of the dental examination and services performed. I understand that Lehigh Valley Health Network will give a copy of the report to the school to allow the school to keep complete health records for my child. This authorization will end when my child is no longer enrolled in the school.

This consent will remain in effect as long as the student/your child is eligible for care or when we receive notification that you would like to terminate care.

I understand that I have the right to revoke this consent at anytime, except to the extent actions have already taken place. If I want to revoke this consent, I must send a letter signed by me to the following: Lehigh Valley Health Network, 17th & Chew Streets, PO Box 7017, Allentown, PA 18105 or fax to 610-969-3084. I understand that if I revoke this consent my child will not receive any more dental treatment from the staff of the Lehigh Valley Mobile Dental Van.

Dental Insurance:

_____ I have no dental insurance for my child.

_____ I do have dental insurance for my child with:

Dental Insurance Co. Name _____

Policy #_____

I give my permission to bill my insurance for all qualifying charges and understand that I will not be balance billed for charges not covered by Medicaid. I appoint my child's school district or its designee as my agent for the sole purpose of signing any insurance forms to certify that a dental service was provided to my child by the Lehigh Valley Mobile Dental Van and the date of the service. For dental services provided to Medicaid recipients, the payment and satisfaction of the claim submitted by the provider of the services will be from Federal and State funds, and any false claims, statements, or documents or concealment of material may be prosecuted under applicable Federal and State Laws.

I have read this consent form. I have had the opportunity ask questions about the information in this form, the Lehigh Valley Dental Mobile Van and the treatment to be given to my child and all of my questions have been answered. I understand this consent.

Full Name of Child (please print) _____

Full Name of Parent/Legal Guardian (please print) _____

Relationship to Child: _____

Phone Number: Mobile_____ **Home** _____

Parent/Legal Guardian Signature: _____**Date:**_____

Child's Name.:_____ Nickname·_____ ☐Male ☐Female ☐Non-Binary

Birth Date:___/___/___ Age:___ School:_____ Grade:_____ Race: _____

Child's Home Phone #: _____ Parent/Guardian cell phone: _____

Child's Home Address:_____

Dental History:

Is your child currently under the care of a dentist? ☐Yes ☐No

Approximate date of child's last dental visit_____

Has the child ever had a serious/difficult problem associated with previous dental treatment? ☐Yes ☐No

Does your child currently have dental pain? ☐Yes ☐No

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Lip Sucking/Biting	☐Yes ☐No	Mouth Breathing	☐Yes ☐No	Nail Biting	☐Yes ☐No
Nursing Bottle Habits	☐Yes ☐No	Clench/Grind teeth	☐Yes ☐No	Thumb/Finger Sucking	☐Yes ☐No

Medical History

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Abnormal Bleeding	☐Yes ☐No	Congenital Heart Defect	☐Yes ☐No	Heart Murmur	☐Yes ☐No
Autism	☐Yes ☐No	Convulsions/Epilepsy	☐Yes ☐No	Kidney/Liver	☐Yes ☐No
ADHD	☐Yes ☐No	Diabetes	☐Yes ☐No	Psychiatric Treatment	☐Yes ☐No
Asthma	☐Yes ☐No	Handicaps/Disabilities	☐Yes ☐No	Rheumatic/Scarlet Fever	☐Yes ☐No
Cancer	☐Yes ☐No	Hearing Impairment	☐Yes ☐No	Other Medical Problems	_____

Please discuss any serious medical problems that the child has had.:_____

Please list all drugs that the child is currently taking:_____

Please list all drugs/materials that the child is allergic to:_____

Does your child require pre-medication (antibiotics) before any common dental treatment? ☐Yes ☐No

Is the child currently under the care of a physician? ☐Yes ☐No

Child's Physician:_____ Phone: (___)_____ Last Visit:____/____/____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental service my child may need.

Signature of Parent or Guardian:_____ Date: ___/_____/_____

Signature of the Provider:_____ Date:____/_____/_____

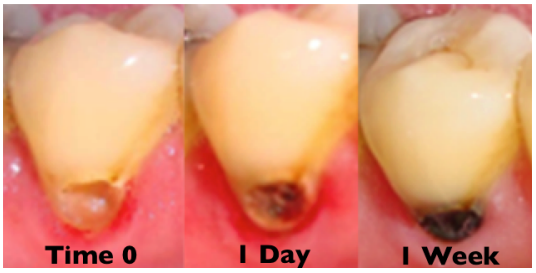
Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

Patient Name:
Date of Birth:
Medical Record Number:

Lehigh Valley Hospital - Department of Dental Medicine

INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE

Facts for consideration:



- Silver diamine fluoride (SDF) is a liquid that helps stop tooth decay. SDF is applied every 3, 6 or 12 months.
- A small amount of SDF is applied to the decayed tooth area.
- After SDF application no eating or drinking for 60 minutes and no tooth brushing until the following morning.
- **The decayed area will stain black permanently.** Healthy tooth structure will not stain.
- I should not be treated with SDF if: 1) I am allergic to silver. 2) There are painful sores or raw areas on my gums or anywhere in my mouth.

Benefits of receiving SDF:

- Helps stop tooth decay.
- Fast.
- Do not need to numb teeth.
- Does not hurt.

Risks of receiving SDF:

- **The affected area will stain black permanently.** This means SDF is working.
- Tooth-colored fillings and crowns may discolor if SDF is applied to them.
- After SDF treatment, a filling or crown might still be needed.
- If accidentally applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off and will disappear in one to three weeks.
- Permanent dark spots if spilled on clothing.
- Allergic reaction.
- Risk that the procedure will not stop the decay.
- Not every cavity can be treated with SDF

Alternatives to SDF, not limited to the following:

- No treatment, which may lead to continued break down of the tooth. Symptoms may get worse.
- Placement of fillings or crowns, extractions or referral to a specialist.

I have read this form. I understand the treatment and have had the chance to ask questions. I have seen the photo of how teeth may look after SDF discolors the cavities. I understand that I may refuse treatment with SDF. I understand that I can decide to have no treatment or I can have fillings, crowns, or extractions done at this or another dental office.

I consent and authorize LVHN Dental Services to use Silver Diamine Fluoride to help stop tooth decay.

Signature of patient/parent/guardian _____ Date_____

Signature of witness_____Date _____