

Optional-Dental-Prevention Works 2026-2027

DO NOT FILL OUT FORM IF YOUR CHILD IS SEEING A DENTIST OR YOU DON'T WANT THEM TO PARTICIPATE

A Dental Hygienist will see your child during school hours (twice per year) to provide: screening, dental cleaning, fluoride, sealants, 10% iodine to suspend bacteria that causes decay, 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 here _____ **IF YOU WANT YOUR CHILD TO BE SEEN-THE ENTIRE FORM MUST BE COMPLETED OR IT WILL BE RETURNED TO YOU TO COMPLETE. IF YOU DO NOT WANT A SERVICE LISTED ABOVE PLEASE INDICATE SO.**

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: _____

ANY ALLERGIES INCLUDING IODINE _____

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-\$60 includes cleaning & fluoride varnish)

13 or older-\$70 ((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. WE DO NOT ACCEPT BLUE CROSS BLUE SHIELD

FILL OUT INSURANCE SECTION. A COPY OF BOTH SIDES OF THE INSURANCE CARD IS NEEDED

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:** _____