

Preventive and Restorative Dental Care Consent Packet

2026-2027

Dear Parent/Guardian,

Cumberland Family Medical Center, Inc., in partnership with Healthy Kids Clinic and the Family Resource/Youth Services Center, is offering dental care at your child's school! A licensed dentist will provide these services in a portable clinic set up inside your child's school.

Preventive Dental Care

✓ Exam, cleaning, fluoride treatment, oral health education, X-rays, and sealants (if needed)

Restorative Dental Care (Grades 1st-12th only)

✓ Fillings, baby tooth extractions, stainless steel crowns, and other necessary treatments

Important Information

- Restorative dental treatment is scheduled separately from preventative dental care.
- An optional consent form is available for SDF Fluoride, which helps stop cavities and reduce sensitivity.
- Not all students are good candidates for dental care in a mobile dental setting. If your child cannot cooperate with dental staff or has multiple areas of large dental decay, they may need to be referred to a local dentist for treatment. Our staff is also limited by the number of days we can spend at your child's school, therefore all treatment may not be completed in a single school year.
- These services are not intended to replace a local dental home.



**YOU MUST SIGN THE FORMS IN THIS PACKET IF YOU
WANT YOUR CHILD TO RECEIVE DENTAL SERVICES!**

***If your child sees a dentist on a regular basis for routine
care, you do not need to sign up for this program.***

Permission for Dental Treatment

School: _____
Grade: _____
Teacher: _____

Student Information (Please Print)

Name: _____ Date of Birth: _____/_____/_____
First Middle Last

Address: _____
Street City, State Zip Code

Sex: _____ Social Security Number (Required): _____ - _____ - _____

Race: ☐ White ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Asian ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Child's Language: ☐ English ☐ Spanish ☐ Other: _____

Parent/Guardian Information (Please Print)

Name: _____
First Middle Last

Relation to Child: _____ Daytime Phone: _____ Emergency Phone: _____

Parent/Guardian's Language: ☐ English ☐ Spanish ☐ Other: _____

Number of People in Household: _____ Annual Household Income: _____

Insurance Information (Please Print)

Dental Insurance Company: _____ ID Number: _____

Whose name is on the policy? _____ Address (If different from above): _____

Policy Holder Date of Birth: _____/_____/_____ Policy Holder Social Security Number: _____ - _____ - _____

Dental History Information

Has the student been to the dentist before? ☐ Yes ☐ No If yes, date of last visit? _____ Name of student's dentist: _____

Does the student have a future appointment with a dental office? ☐ Yes ☐ No Purpose of Visit: _____

Is there anything else we should know about the student's health or about any dental care he/she has had in the past? If so, please explain:

Please mark the following box to give consent for services:

- ☐ **Yes**, I give consent for the named student to receive the dental services listed below. I also give consent for the named student to receive these services without a parent/guardian present. I understand the use of local anesthetics (numbing) carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.

Preventive Services

- Dental Exam
- Intra-oral Photos (pictures of teeth and surrounding tissue only)
- Prophylaxis (Cleaning)
- Fluoride Treatment
- Dental X-rays
- Dental Sealants

Restorative Services (Grades 1st-12th only)

- Dental Anesthetic (numbing)
- Simple extractions of baby teeth
- Treatment of decayed or broken teeth with filling or stainless steel crowns
- Other treatment deemed necessary by dentist
- Treatment of infected teeth or gums

Would you like to receive a **phone call** at the number listed before your child's first **restorative** dental treatment?

☐ **No**, a phone call is not necessary.

☐ **Yes**, please call the number listed above before the first RESTORATIVE (fillings, etc.) dental treatment visit. If you cannot reach me, I still give consent for my child to receive these dental services. I understand that I will not get a phone call prior to PREVENTIVE (exam, etc.) dental services, only before the first visit for RESTORATIVE dental services. I understand this phone call will not come on the date of service.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

By signing above, I understand that Cumberland Family Medical Center, Inc. shall provide a copy of its Notice of Privacy Practices upon my request, which is also available at www.cumberlandfamilymedical.com. By signing this form, I give consent for my child's dental insurance to be billed. I understand that these services are subject to my insurance plan's limitations and maximums. I understand it is my responsibility to notify Cumberland Family Medical Center, Inc. regarding any restrictions to disclosure of my health information regarding this or any subsequent visit. I also give consent for the named student's dental records to be shared with their local dental home, necessary school staff, and the parent/guardian listed above. I also give consent for an Avesis dental consultant to perform sealant rechecks up to one year after the sealant is placed.

Please complete back of form



Patient Name: _____ Birthday: _____

Dental / Health History

Health History: (Please circle your answers.)

Circle if your child NOW has or has EVER had any of the following health problems:		
Yes	No	Rheumatic Fever/Mitral Valve Prolapse/Heart Problems If yes, please explain: _____
Yes	No	Is child supposed to take antibiotics before dental care? If yes, please explain: _____
Yes	No	My child is ALLERGIC to MEDICINES (like antibiotics): Please LIST the medicines your child is allergic to here: _____
Yes	No	My child is ALLERGIC to something other than a medicine. Please list your child's other allergies here: _____
Yes	No	Diabetes
Yes	No	Epilepsy/Seizures
Yes	No	Asthma
Yes	No	Sensory Impairment, ADHD, ADD, or on the Autism Spectrum <i>*If yes, please circle one.</i>
Yes	No	My child takes MEDICINE every day for a health condition. Please LIST medicines here: _____
Please list any other medical or behavioral health conditions:		

Dental History: (Please circle your answers.)

How long has it been since your child VISITED a dentist?	NEVER	Less than 6 Months	1 Year	2+ Years
*What was the main reason for your child's last dental visit?				
In the past 6 months, did your child have a TOOTHACHE ?			Yes	No
Describe the condition of this CHILD'S TEETH :		Poor	Fair	Good
Describe the condition of the PARENT/GUARDIAN'S TEETH :	Dentures/NA	Poor	Good/Fair	Excellent
		<i>High</i>	<i>Medium</i>	<i>Low</i>
Child has several sugary snacks/drinks between meals		3 or more	Sometimes	Only at mealtime
Child has had fillings or visible cavities		Yes		No
Child has special health care needs that make it hard to brush (developmental, mental, physical disabilities)		Yes (age 0-14)	Yes (over age 14)	No
Child has plaque on teeth			Yes	No
Child takes medications that cause dry mouth			Yes	No
Child drinks city water (has fluoride), brushes daily with toothpaste, or has fluoride applied by dentist every 6 months			No	Yes

For Administrative use only. Please do not write in this box.

Informed CONSENT for Silver Diamine Fluoride

Facts:

Silver Diamine Fluoride (SDF) is similar to a liquid antibiotic. We use it on cavities to help STOP TOOTH DECAY and to treat tooth sensitivity. An application of SDF may be needed every 6 to 12 months.

Treatment with SDF does not replace the need for dental fillings or crowns to repair tooth function or appearance.

You should not be treated with SDF if you are allergic to silver or there are painful sores or raw areas anywhere in your mouth.

Directions for use:

1. Dry the affected area.
2. Place a small amount of SDF on the affected area.
3. Allow to dry for one minute.
4. Rinse.



Benefits:

SDF can help **STOP TOOTH DECAY**. SDF can help relieve sensitivity.

Risks:

Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that this procedure will not stop the decay, and there is no guarantee that treatment will be successful.

The affected area will stain black permanently (see photo above), but the decay will STOP.

A healthy tooth structure will not stain. A stained tooth structure can be replaced with a filling or a crown.

Tooth-colored fillings and crowns may also change color if SDF is applied to them. This is normally temporary and can be polished off.

If accidentally applied to the skin or gums, a harmless brown or white stain may appear. It does not wash off but will disappear in one to three weeks.

You may notice a metal taste; this will go away quickly.

If tooth decay is not stopped, it will continue, and the tooth will require further treatment such as another SDF, a filling or crown, a root canal, or removal of the tooth.

Alternatives:

No treatment: May lead to continued deterioration of tooth structures and appearance; symptoms may increase in severity.

Other options: (depending on location and extent of decay) fluoride varnish, a filling or crown, extraction, or referral for more advanced treatment.

I certify that I have read and fully understand this document.

Please Print Student's First and Last Name

Student's Date of Birth

SIGNATURE of Parent or Guardian

Date