Name	MC Ver N R	Fall	MC ReVer	Spring

Smiles for Life, PA

2021 / 2022

Dear Parent or Guardian:

If you do not wish for your child to participate in the school dental clinic *DO NOT FILL OUT THIS FORM*.

A Dental Hygienist will see your child during school hours to provide oral inspections, cleanings, oral hygiene instructions, fluoride varnish, sealants, temporary fillings, and/or Silver Fluoride (SF). SF is used to temporarily manage cavities until your child can get permanent fillings from a dentist. When decay is treated with SF, the tooth will turn dark. This is a good indication that the infection in the tooth is dying. If you do not want SF used, please check this box ☐. A report will be sent home with our findings. **Please complete and return this permission slip ONLY if you would like your child to participate.**

If there are any medical changes in the health of the child during the year, please notify the school nurse. We will notify the school nurse if your child needs emergent care. Parents/guardians that choose self-pay will be contacted by Smiles for Life before the clinic date to discuss services and cost, and payment procedure. Parents/guardians that choose to withdraw a child after enrolling must contact Smiles for Life.

THIS PROGRAM DOES NOT REPLACE AN EXAM BY A DENTIST.
If you have any questions, please call Stormy Colbath, IPDH at 270-1454.

Child's Name: _____ **Date of Birth:** ____-____-____ **Sex: M** ____ **F** ____
(As it appears on the MaineCare Card, PLEASE PRINT CLEARLY)

School Name: _____ **Teacher:** _____ **Grade:** ____

❑ MaineCare

Maine Care Number:

_____
(9-digit number on front of card)

❑ Self-Pay (includes Cleaning and fluoride varnish)

❑ 12 or younger ($42.00) ❑ 13 or older ($52.00)

❑ Cash ❑ Money Order (payable to Smiles for Life, PA)

❑ Debit or credit card # _____

Name on Card: _____

Expiration date: _____ 3-digit code: _____ Billing ZIP code: _____

Email for receipt: _____

❑ Dental Insurance (MUST be complete. ALL information is required. A copy of both sides of ID card is very helpful.)

Insurance Company: _____

Insurance Co. Claims Address: _____ ZIP Code: _____

Phone: _____ ID Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Employer & Address: _____ ZIP Code: _____

Home Address: _____

City/Town: _____ ZIP Code: _____

Parent/Guardian Phone Numbers (Check best) Home: ❑ _____ Cell: ❑ _____ Work: ❑ _____

Allergies, Current Medications, Medical Conditions _____

_____

Do you have any dental questions or concerns? _____

Has s/he seen a dentist or hygienist? Y___ N___ Date of last visit ____-____-____

Dentist's Name or location of last visit: _____

Yes, I give permission for my child to be seen *throughout the school year*. I will notify the school nurse of any changes in the medical history. I understand that Smiles for life, PA is HIPAA compliant and all records are kept confidential and that claims to MaineCare insurance will be electronically transferred. **By signing below, you are giving SFL permission to share medical/dental information with other health professionals.**

Signature _____ Date _____

Please PRINT your name _____