Lincoln County Dental, Inc.

CHOMP Community Health Outreach Mobile Program
P.O Box 253 chomp@lcdental.org
Wiscasset, ME. 04578 (207) 386-6600

If your child sees a dentist outside of school, and has regular check-ups, you do not need to complete this form.

We encouraged people who receive regular dental care with a dentist to continue care with their dental home. Your child would not qualify for services by Lincoln County Dental- CHOMP if your child has dental home and is receiving regular care.

Your child qualifies for services from Lincoln County Dental- CHOMP if he/she has not received dental care in the prior 6 months and:

- has MaineCare
- has Free/Reduced Lunch
- OR has no dental insurance (a reduced fee may be requested for services rendered)

☐ I give CHOMP permission to bill MaineCare for my child's services.

MaineCare #: _____

☐ My child qualifies for free/reduced lunch

☐ My child does not have dental insurance

☐ My child does have a dental home and receives dental care. I do not want to sign him/her up for services offered.

Dental Hygiene Services:

Dental Prophylaxis (Cleaning) ■ Dental Sealants ■ Dental Related Education
Dental Hygiene Screening ■ Fluoride Applications ■ Silver Diamine Fluoride ■ Oral Hygiene Instructions

I understand that the services to be delivered do not take the place of an examination by a dentist. X-rays are not included; an annual exam by a dentist is still recommended.

In signing below, I grant Lincoln County Dental- Children's Health Outreach Mobile Program permission for all above Dental Hygiene services as recommended/needed (unless otherwise noted on this form) to be rendered by an Independent Practice Dental Hygienist.

Child's Name **Grade/Teacher** **Date**

Parent/Guardian Signature **Print Name** **Relationship to Child**

Email **Your Daytime Contact Number**

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Patient's (Child's) Name:	Date of Birth:	Gender (optional):
Home Address:	City: State: Zip:	
School:	Teacher/Grade	
□ Previous Dentist: □ Lincoln County Dental-CHOMP	Date of last visit:	
Child's Physician:	Date of last visit:	

Medical History

Is the child currently being treated for any illnesses? □ Yes □ No
Explain: _____
Is the child taking any prescription medications? □ Yes □ No
List: _____
Does your child have any allergies (food, latex, penicillin, antibiotics, etc.)? □ Yes □ No
Explain: _____
Has the child ever been hospitalized? □ Yes □ No
Explain: _____
Has your child ever had a cavity or filling? □ Yes □ No
Has your child ever required premedication (antibiotics) prior to dental treatment? □ Yes □ No

Does the child have a history of any of the following conditions?

□ ADHD/ADD □ Anemia □ Asthma □ Bladder □ Bleeding Disorder
□ Bones/joints □ Cancer □ Cerebral Palsy □ Cold sore/Fever Blisters
□ Diabetes □ Fainting □ Heart Murmur/Malformation □ Hepatitis
□ High Blood Pressure □ Kidney Disease □ Pregnancy □ Rheumatic Fever □ Seizures
□ Thyroid Problems □ Tuberculosis □ Other _____

Verification of Information

I affirm that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my child's medical status.

Parent/Guardian Signature **Relationship to Child** **Date**

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Notice of Privacy Act and Release

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form be kept confidential. The federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.
I have reviewed CHOMP's program *Notice of Privacy Practices and Release* and understand that more information is available upon request. I also give CHOMP permission to obtain or release my medical or dental records to/from the names listed below. If individuals are NOT to receive information, please place NONE in the space below.

- ✓ Lincoln County Dental
- ✓ Child's School
- ✓ Previous Dentist
- ✓ Dentist of Referral
- ✓ Primary Care Physician/Pediatrician
- ☐ Other: _____

Child's Name **Grade/Teacher** **Date**

Parent/Guardian Signature **Print Name** **Relationship to Child**

No expiration until required by law.