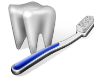

Choptank Community Health System
School Based Dental Program Enrollment and/or Update Form
Healthy Children Are Better Learners
DENTAL

Dear Parent/Guardian:

As a student in the **Caroline, Dorchester** and **Talbot** County Public School system, your child has access to the **School Based Dental Program**. The program is a partnership between the Public Schools, County Health Departments and Choptank Community Health System (CCHS).

Services: May include: a dental screening, cleaning, fluoride treatment (which may possibly be applied two times during the school year), sealants and if needed, referrals for prescriptions and dental emergencies.

The CCHS School Based Dental staff utilizes progressive mobile dental equipment and follows all regulations regarding appropriate sterilization, safety and health procedures. Whenever your child is seen by the School Based Dental staff, a note is sent home that details the visit. You will receive information on your child's oral health status as well as a list of the services provided during the visit. Additionally, a report on your child's visit is shared with your child's dentist, if you list one on the enrollment form.

The School Based Dental program does not take the place of your primary dentist. A dental hygienist will screen your child to determine which services will be provided or if a referral is necessary. The hygienist provides care that promotes healthy teeth and gums.

Your child should go to your dental office for a complete exam with x-rays as often as recommended by your dentist.

Cost: The Medicaid Healthy Smiles program covers preventive dental services in the school setting. If your child has dental insurance, we will bill the insurance company for dental services and follow the billing requirements associated with your plan. Depending on your insurance plan, you may receive a bill from CCHS for copays, unmet deductibles and any non covered services. If CCHS is not a participating provider with your dental insurance plan, you will be billed directly for services. If you do not have insurance, we offer a sliding fee scale. Patients on the sliding fee scale will be billed based upon their income. All patients are eligible to apply for the sliding fee program even if they have insurance.

Enrollment: All Caroline, Dorchester and Talbot County Public School students can enroll in the program. Please complete the attached enrollment form and return it to the school nurse. Once your child is enrolled in the School Based Dental program, they will not need to re-enroll each year, however, updated information will be obtained yearly. If you have questions about the program, please contact Choptank Community Health System at (410) 479-4306, ext. 5012.

Additional Information

What are sealants?

- Sealants are a thin, plastic coating painted onto the chewing surfaces of permanent teeth. They provide protection for your child's teeth by acting as a barrier to prevent cavities from damaging the teeth. Sealants are applied by dentists or dental hygienists.

What is Fluoride?

- Fluoride is a naturally occurring mineral. It is present in water at varying levels.
- Fluoride varnish is painted on the teeth. It is quick and easy to apply and **does not** have a bad taste.
- Fluoride varnish is different because it works to help make teeth strong on the outside.

Brushing Tips

- Always use a soft-bristled toothbrush.
- Replace your toothbrush every **three** months.
- **Never** share a toothbrush, it spreads germs.

Flossing Tips

- Flossing cleans between the teeth where a toothbrush can't reach.
- You can begin flossing when any two teeth touch

My child is a student at: ________________________________ School

☐ Caroline County ☐ Dorchester County ☐ Talbot County

Student's name ____________________ ____________________ ____________________
Last First Middle

Home address ____
Street City State/Zip

Phone______________________ Social Security# ____________________ ☐ Male ☐Female

Date of Birth ______________Race ____________ Hispanic/Latino? ☐ Yes ☐ No

Grade ________ Teacher/ Homeroom ____________________ Email____________________

Parent/legal guardian name ____

Relationship to student ____

Address (if different than student) ____

Phone: Home __________________ Work __________________ Cell __________________

Additional Contact Information:

Name ____________________________________ Phone ____________________________

Relationship to student ____

DOES YOUR CHILD HAVE DENTAL INSURANCE?

☐ Yes Please complete the following. ☐ No ☐ Please send a sliding fee program application.

Name of insurance company ____

Policy/Medical Assistance # ____

Group # ____

Insurance billing address ____

Policy holder name ______________________________ **Policy holder DOB** ____________

Name of DENTIST______________________________ **Phone #** ____________________

Date of last dental visit ____

Date of next cleaning ____

Name of DOCTOR ______________________________ **Phone #** ____________________

I understand that my signature gives consent for the CCHS School Based Dental Providers to provide dental services for my child and to communicate with my child's primary dental care provider. I understand that my signature indicates that I have had the opportunity to receive and review the Choptank Community Health's Notice of Privacy Practices. *I give CCHS permission to call my home, leave a message on a machine or with a person regarding healthcare information. CCHS may also mail dental care information to my home. I understand that my child's dental information will be used for treatment, payment and health care operations. I recognize that school directories may be used to obtain information left blank on the enrollment form. I understand that services provided to my child will be billed to my insurance carrier or Medical Assistance. I may receive a bill from CCHS for copays and/or deductibles. If I do not have insurance, I will be billed for the full cost of services or with a sliding fee discount if applicable.*

Parent/Guardian Signature:______________________________ **Date:**____________________

Please complete back of form➔

School Year: ____________________

Student's Name: ____ **Date of Birth:** ____________________

List all medications your child takes daily or, on a regular basis:

Medication _______________________________mg _______ Directions ______________________

Does your child have Allergies to:

Medication ☐ No ☐ Yes Name of medication(s) ____

Reaction to medication(s) ____

Food Allergy ☐ No ☐ Yes Source of Allergy ____

Does your child have a doctor's order for an Epipen? ☐ No ☐ Yes

DENTAL HISTORY: Please circle Yes or No.

YES NO Has your child complained of mouth pain within the last six months?
YES NO Does your child routinely visit a dentist for six month check ups?
YES NO Do you need help in finding a dentist?

DOES YOUR STUDENT HAVE/HAD ANY OF THE FOLLOWING? CONDITIONS	CHECK ALL THAT APPLY TO THIS STUDENT	ADDITIONAL INFORMATION TO HELP US BETTER SERVE YOUR CHILD'S DENTAL NEEDS
ADD/ADHD		
ASTHMA♦WHEEZING♦BREATHING		
BLEEDING DISORDER		
CANCER		
DEPRESSION ♦ MENTAL ILLNESS		
DEVELOPMENTAL DISABILITIES		
DIABETES		
DRUG ♦ALCOHOL ♦ TOBACCO USE BY STUDENT / HOUSEHOLD		
HEARING♦VISION PROBLEM/LOSS		
HEART PROBLEMS ☐ Congenital ☐ Requires Antibiotics		
HIGH BLOOD PRESSURE		
HIV/AIDS		
JOINT REPLACEMENT		
LEAD POISONING		
LIVER PROBLEMS (HEPATITIS)		
SEIZURE DISORDER(EPILEPSY)		
TUBERCULOSIS		
ANY OTHER HEALTH ISSUES:		
	History Reviewed	*Documentation in Case Note*

Please return this form to your school nurse