ToothSavers℠

TOOTHSAVERS IN-SCHOOL DENTAL CARE
MEDICAID PAYS 100%

ECEAP/Head Start students are 100% covered by Medicaid for services and these families will not be billed.

Sign Up Online!
www.MySchoolDentist.com
Scan the code with your phone.

SIGN AND RETURN TO YOUR SCHOOL TODAY!

ToothSavers in-school dental program will be providing NO COST visual screenings and preventive oral health services at your child's pre-school. **These visits are quick and fun, and your child will receive a free toothbrush.**

Oral health screenings are a visual screening to check the health of the teeth/mouth and detect any dental problems or emergencies. **Every child will receive a visual screening unless you opt out with your child's school.** NOTE: Screenings are different than dental exams and do not interfere with regular dental office exams.

If you would like your child to receive the **preventive services** listed below, you need to fill out and return this form to your child's school:

Fluoride varnish is a safe, great tasting gel brushed onto the teeth by a dental professional. It helps fight cavities and is recommended for kids 2-4 times per year.

Dental sealants are a safe and painless coating placed on chewing surfaces of the back teeth. According to the CDC (Centers for Disease Control and Prevention) sealants prevent cavities by up to 80%!

Head Start children under 18 months will have screenings only.
Children 18 months to 3 years may receive fluoride.
Dental sealants are offered to children 3 years and older.
Our screenings count as ECEAP/Head Start dental health encounters for enrollment purposes.

PLEASE CHECK THE SERVICES YOU WOULD LIKE YOUR CHILD TO RECEIVE:

☐ **Fluoride varnish**
(mineral applied to protect & strengthen teeth)

☐ **Sealants**
(to protect back teeth from cavities)
Dental sealants are only covered by insurance every three years though so please inform your child's dentist if ToothSavers provided this service.

PLEASE COMPLETE

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Child's Legal FIRST Name	Child's Legal LAST Name(s)	Birth Date mm/dd/yyyy	☐ Male ☐ Female
Address	City	State	Zip
School	Teacher		Grade
Parent/Guardian Name		Phone ( )	
Email		Alt Phone ( )	

FOLD

FOLD

IMPORTANT HEALTH QUESTION

DOES YOUR CHILD HAVE ANY THE FOLLOWING CONDITIONS? PLEASE CHECK EACH CONDITION THAT APPLIES. IF NO CONDITIONS APPLY, LEAVE BLANK.

☐ Allergies-foods/seasonal
☐ Allergies-medications
☐ Allergy to silver
☐ Asthma
☐ Autism spectrum
☐ Behavioral disorder
☐ Diabetes
☐ Heart murmur
☐ Heart problems
☐ Hepatitis or HIV
☐ Seizures
☐ Sensory disorder
☐ Other / Explain _____

Other health problems we should be aware of: _____

IF YOUR CHILD HAS MEDICAID/CHIP (APPLE HEALTH)

Enter their **ProviderOne** number ending in WA here: → ☐☐☐☐☐☐☐☐☐ **W** **A**

OR Child's Social Security # (if available) ☐☐☐ – ☐☐ – ☐☐☐☐

The Health Insurance Portability and Accountability Act 1996 (HIPAA) requires that all health care records be kept confidential. ToothSavers adheres to all HIPAA standards and will provide a Notice of Privacy Practices upon request.

READ & SIGN BELOW

By signing below, I consent for my child to enroll in the ToothSavers preventive oral health program and receive preventive services. Permission includes initial dental care & follow-up visits. If you wish for your child to be exempt from the screening please inform the school.

SIGN & DATE HERE _____ _____
DATE

For your privacy, please fold & secure.

QUESTIONS: 855-481-8639 FAX: 888-330-4331 Visit us at: ToothSavers.org

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