Name Per EDS or Class Roster /DOB ________________________________/____________

Office USE ONLY

☐ EDS________________

☐ DSP________________

☐ REG________________

☐ SCAN/Initials___________

SCHOOL-BASED ORAL HEALTH PROGRAM

CONSENT FORM
(**PREVENTATIVE** ORAL HEALTH SERVICES)
SCHOOL YEAR 2019-2020

Dear Parent/Guardian,
Ascension Columbia St. Mary's is offering an oral health program for children in your school. ***You will not receive a bill for services.***

Use **INK** when filling out this form.

Child's Last Name: ________________________________ Child's First Name: ___________________________

Child's Date of Birth: _____/_______/________ Male ____ Female ____ Phone Number: (________)______________________

Child's School: ___________________________ Grade: ______ Room Number: ____________

- I have read and understand this consent form.
- I understand the program includes a dental screening. Other preventative services will be provided as needed: dental sealants, fluoride treatments, oral health education, teeth cleaning, and, to the extent applicable, a comprehensive oral exam (including radiographs).
- I was given the opportunity to ask questions by calling 414-383-3220. All questions I had were answered in a satisfactory manner and I understand that I have the right to be provided with answers to questions that may arise in the future by calling the same number.
- I understand the nature of the treatment to be provided and hereby authorize Ascension and its licensed dental professionals to perform the preventative oral health and diagnostic services listed above on my child.
- I have reviewed the health questions on the back of this form and answered them accurately to the best of my knowledge. I understand that the answers I have provided will be used to determine the appropriate dental treatment for my child, and I agree to notify Ascension if any changes in my child's health status occur.
- I acknowledge that I have received the Ascension Notice of Privacy Practices that explains how information collected for treatment may be used or disclosed to my insurance company or other health care providers. I authorize Ascension to bill Forward Health/Medicaid/ Badgercare for the services provided to my child.
- I understand that this consent is effective for the school year for which it was signed and any subsequent summer programs in order to provide follow-up services, including multiple fluoride treatments.
- I understand that I may revoke this consent for treatment at any time prior to the treatment. I may do so in writing to the Ascension St. Elizabeth Ann Seton Dental Clinic at 1730 S. 13th Street, Milwaukee, Wisconsin 53204.

PLEASE CHECK "YES" or "NO" BELOW AND THEN SIGN AND DATE BEFORE RETURNING TO YOUR CHILD'S SCHOOL.

☐ **YES**, I do want my child to participate in Smart Smiles. **(Sign & fill out the *rest* of the form)**

☐ **NO**, I don't want my child to participate in the school-based dental prevention program. **(ONLY fill box above and sign)**

IF NO, PLEASE EXPLAIN WHY:

_____________________________/ _______________________________ ____/____/_______
(Print) parent/guardian **(signature) parent/guardian** **Date**

What type of **DENTAL insurance** does your child have? (Check **ALL** that apply)

☐ Forward Health/Medicaid **LIST YOUR CHILD'S 10 DIGIT FORWARD HEALTH/MEDICAID CARD #**_________________

☐ Private Insurance (i.e. Delta, Cigna) ☐ No Insurance ☐ Other:

Has your child been seen by a dentist in the last year?	☐ YES	☐ NO	
Ethnicity (select **ONE**):	☐ Hispanic	☐ Non-Hispanic	☐ Unknown/Not Provided
Child's Race (Check **ALL** that apply):	☐ White	☐ Black/ African American	☐ Asian
	☐ American Indian/Alaska Native	☐ Native Hawaiian/Pacific Islander	☐ Unknown/Not Provided
Primary Language Spoken by Family:	☐ English	☐ Spanish	☐ Arabic
	☐ Burmese	☐ Karen	☐ Somali ☐ Other

PLEASE FILL OUT THE HEALTH QUESTIONS ON THE BACK OF THIS FORM

If the health questions are not fully answered, WE MAY NOT PROVIDE all SERVICES TO YOUR CHILD.

ANSWER ALL HEALTH QUESTIONS

IF YOUR CHILD HAS NO HEALTH CONCERNS CHECK HERE ☐

Does your child have any of these health conditions or diseases? CHECK ANY THAT APPLY

- ☐ Artificial Heart Valve
- ☐ Congenital Heart Defect
- ☐ Organ Transplant
- ☐ Sickle Cell Disease
- ☐ Asthma
- ☐ Diabetes
- ☐ Bleeding Disorders
- ☐ Seizures
- ☐ Heart Disease
- ☐ Compromised Immune System
- ☐ Allergies to:___________________
- ☐ Heart Surgery in last 6 months
- ☐ Cancer
- ☐ Other- Please list

Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? If yes, please explain:	YES	NO

1. Does your child use medicine prescribed by a doctor? If YES, please list medications:	YES	NO
2. Does your child need or use more medical care than other children their age?	YES	NO
3. Does your child have trouble doing things most children the same age can do?	YES	NO
4. Does your child get special therapy, such as physical, occupational or speech therapy?	YES	NO
5. Does your child need counseling or treatment for behavioral problems, emotional problems, or delays in walking, talking or activities other children the same age can do?	YES	NO
6. *If you selected **YES*** to questions 1-5, has this problem lasted *or* is expected to last at **least 12 months**?	YES	NO

Note: This program will bill Forward Health/Medicaid/Badgercare insurance for covered children. No child will be refused services based on their insurance status. **The treatment which your child will receive in this program is not meant to be an alternative to regular dental care. It is still strongly recommended that you seek out a dental home (family dentist) for routine dental care including any follow up care which may be recommended after your child has completed this school based oral health program.** For questions or concerns, contact Smart Smiles with St. Elizabeth Ann Seton Dental Clinic 1730 S. 13th Street • Milwaukee, Wisconsin 53204 • Phone 414-383-3220 • Fax: 414-383-3363

Visit #1:_______ TX Urgency ______	Visit #2:_______ TX Urgency ______	RDH REVIEW	Nurse Consult Completed Y/N Findings:

03-6812-15 Revised 4/08/2019