At No Cost to the Child or their Family

DENTAL CLEANING AND SEALANT PERMISSION SLIP

Preferred Dentistry Associates of Wisconsin, LLC ("Group") will be traveling to your child's school to perform a dental screening, prophylaxis (cleaning), application of topical fluoride and the placement of sealants on all permanent molars. A written summary of our services and evaluation will be furnished to the school nurse. Our Group will make every effort to return in six months, if scheduling allows, after the initial screening for follow-up prophylaxis, application of fluoride and placement of sealants.

CHECK ONE OF THE FOLLOWING:

○ **I DO authorize the Group to treat the child named below and to disclose information regarding such treatment to the school.**

○ **I DO NOT authorize the Group to treat the child named below. I understand by selecting this option this child will not receive dental services from the Group.**

Reason for not participating: ______________________________

If you authorize treatment, please fill out and sign the authorization granting your permission and complete your child's medical history below:

Name of School:_______________ Grade: _____ Classroom/Teacher: ______________

Dependent's First Name: __________________ Last : _____________________ Middle Initial: _____

○ Male ○ Female Date of Birth (DOB): _____/_____/_____ Ethnicity (select one): ○ Hispanic ○ Non-Hispanic ○ Unknown

Race (select one): ○ White ○ Black ○ Asian ○ Native American ○ Native HI/Pacific Islander ○ Other:__________

Parent/Guardian's First Name: _______________Last : ________________Phone (___)_______-_______

Street Address________________________City/State/Zip:_________________

Insurance Information:Please check all that apply. No child will be refused based on their insurance coverage

○ Forward Health/Medicaid/BadgerCare: If so, Wisconsin Medicaid #: ______________________________

○ Private Dental Insurance ○ No Dental Insurance ○ Other __________

Student's Health History – Please complete

Does your dependent:

Use medicine prescribed by a doctor? ○ Yes ○ No **If yes, what kind?:** ______________________

Need or use more medical care than other children the same age? ○ Yes ○ No

Have trouble doing things most children the same age can do? ○ Yes ○ No

Need or get special therapy, such as physical therapy, occupational therapy or speech therapy? ○ Yes ○ No

Need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking, or activities that other children the same age can do? ○ Yes ○ No

If you checked any of the boxes above:

Has this problem lasted or is expected to last at least 12 months? ○ Yes ○ No

Does your child have any allergies (i.e. medications, latex, food ect.) ○ Yes ○ No **If yes, what type?:** ______________________

Does your child see a dentist regularly? ○ Yes, within 1 year ○ Yes, over 1 year ago ○ Never

Name of your child's primary dentist: _______________________

I, Parent or Legal Guardian (please print name), ________________________ give my consent for the child named above to participate in the school-based oral health program, which includes a dental screening, dental prophylaxis (cleaning), fluoride treatment and the application of sealants on permanent molars. I understand that these services will be performed by registered dental hygienists employed or contracted by Preferred Dentistry Associates of Wisconsin, LLC, and that my child may be randomly selected at a follow-up visit to determine the quality of dental work performed by these hygienists. I understand that my failure to give consent will exclude my child from participating in this program. I authorize Preferred Dentistry Associates of Wisconsin, LLC to use my child's Medicaid or Kid Care recipient number or insurance group and policy numbers for billing purposes only. I have answered the questions in the medical history to the best of my knowledge. I understand that the treatment which my child will receive in this program is not meant to be an alternative to regular dental care. It is still strongly recommended that I seek out a dental home (family dentist) for routine dental care, including any follow-up care which may be recommended after my child has completed this school-based oral health program.

Signature of Parent/Legal Guardian ____________________________ **Date** ___/___/___

!! RETURN THIS PAGE TO SCHOOL !!

A copy of our Notice of Privacy Practices is available at the offices of the Company or by calling (414) 431-8764