



Simply Smiles Dental Consent Form

Please complete this form to opt-in for dental services

Services Offered: oral screening , x-rays, caries risk assessment, prophylaxis, fluoride application, nutritional counseling, tobacco counseling, oral hygiene instruction, sealants, caries preventive medicaments, interim caries arresting medicaments, re-mineralization treatments, intraoral images, and protective restorations.

Last _____ First _____

School: _____ Teacher: _____ Grade _____

Mailing Address: _____ Town _____ Zip: _____

Date of Birth: ____ / ____ / ____ Age: _____ Gender: Male Female

MaineCare #: _____ A Other Dental Ins #: _____

Other Dental- Subscriber Name & DOB: _____

Medical:

Circle medical diagnosis: ADD, ADHD, Anxiety, Asthma, Autism, Bleeding Disorders, Cancer, Depression, Diabetes, Heart Problems, Kidney Disease, Liver Disease or any other: _____

List Medications: _____

List allergies: Milk, Lactose intolerant, Dyes, Environmental allergies, Food, Gluten, Latex, Medication, Iodine, Silver

or Other: _____

Does your child require antibiotics prior to dental procedures? Yes / No Epi-Pen at school? Yes / No

Consents to Treat: (A dental hygienist is not a dentist and the service to be rendered does not constitute comprehensive restorative care)

#1 - I give Simply Smiles permission for my child to receive all the above listed services, unless otherwise instructed by me, the parent/guardian, to be provided by the (IPDH) independent practicing dental hygienist and bill the insurance carrier listed above.

#2 - I give permission for Silver Diamine Fluoride (SDF) (interim caries arresting medicament) to be placed on areas of decay or incidences. I have read and understand the information on page 2 (back side) of this consent form.

#3 – I give permission to request or release confidential information on the above-named child for the purposes of accessing eligibility, obtaining an oral health screening, providing care and in making referrals for the benefit of the child. This applies to information exchanged to and from the school nurse and to the dentist whom your child is being referred to.

When was your child last seen by a dental provider? _____

Previous Dental Provider: School based dental program Dentist

(Print) Parent/Guardian: _____ Date: _____

Email address: _____ Phone: _____

*Signature: _____

General Information

HIPAA Policy Disclosure: I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: - Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly. - Obtain payment from third-party payers. - Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Simply Smiles has the right to change its Notice of Privacy Practices from time to time and then I may obtain a current copy of Notice of Privacy Practices. This personal information will not be shared with anyone other than the person listed on the “Parent/Guardian Consent to Treat”, page one, without a HIPAA request form. If you would like a copy of Simply Smiles’ HIPAA Policy, it can be downloaded from our website. www.simplysmiles.me

I understand it is my responsibility to contact Simply Smiles if my child has had a dental appointment in another office prior to being seen at school. I understand if my child does not qualify for this service I will not be notified, and the consent form will be shredded. I understand that the dental hygiene services that will be delivered by an IPDH or PHS is not a dentist and that the service to be rendered does not constitute restorative care or treatment.

Temporary Filling Policy/ Protective Restoration: A temporary filling is not a permanent fix. You still need to take your child to have the temporary filling evaluated. If your child does not see a dentist their condition could get worse.

Silver Diamine Fluoride: Silver Diamine Fluoride (SDF) is a drill-less treatment for tooth decay. SDF is a liquid applied to your child’s tooth, then washed away. SDF has been used globally for decades and was FDA approved by the U.S. in 2014. It should not be used for anyone with a known silver allergy. Simply Smiles may determine that cavity treatment with SDF is appropriate. Rather than sending your child home with active disease (cavity), we will try to stop the disease progression with an SDF treatment (caries arresting medicament).

Benefits of Silver Diamine Fluoride

- Helps to stop the progression of decay.
- Stains visible and hidden tooth decay for you to see.
- Is a No Needle/No Drill alternative.
- SDF treatment can help stop tooth pain.
- No known side effects other than cavity staining.

What to Expect

- SDF only stains decay, not healthy parts of a tooth.
- Treatment helps stop the spread of disease.
- Treatment provides time to seek additional care.
- The tooth staining associated with SDF can take days to appear or be seen immediately. If SDF inadvertently touches your child’s skin, you will see temporary tattooing. This is not a health concern and will fade within 1-3 days.

