



# 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](http://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.

Are there any of the above services that you would **NOT** like your child to receive?

If so, please list here: \_\_\_\_\_

## PLEASE COMPLETE

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Child's Legal Name		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		City	State
			Zip
School		Teacher	
		Grade	
Parent/Guardian Name		Phone ( )	
Email		Alt Phone ( )	

## IMPORTANT HEALTH QUESTION

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

- |  |  |                                       |   |   |
|--|--|---------------------------------------|---|---|
| <input type="checkbox"/> Allergy to silver         | <input type="checkbox"/> Autism spectrum     | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Heart problems   | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Behavioral disorder | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis or HIV | <input type="checkbox"/> Sensory disorder |
| <input type="checkbox"/> Other _____ Explain _____ |  |                                       |   |   |

**Allergies or 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)  -  -

## PRIVATE DENTAL INSURANCE

<b>Ins. Company Name</b> ( <i>not Medicaid</i> )	Ins. Phone ( ) -
Group #	Co. Phone ( ) -
Insured Adult Name	Insured Adult Birthdate / /
Member ID/Policy #	Insured Adult SS# - -

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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**ESPAÑOL AL REVERSO**



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