TOOTHSAVERS OF WASHINGTON ORAL HEALTH PROGRAM

Toothsavers Oral Health Care Program will be providing preventive oral health services at your child's pre-school on _____. Services include oral screenings, fluoride varnish, and dental sealants. Please note: Dental sealants are offered to children 3 years and older, 18 months -3 yrs. may receive a fluoride treatment but, not sealants.. Headstart kiddos under 18 months will have screenings only. Our screenings count as ECEAP/Headstart dental health encounters for enrollment purposes. These visits are quick and fun, your child will receive a free toothbrush..

Medicaid, Apple Health, Molina cover our services at 100%. Every child will receive a visual screening unless you opt out with your child's school . If you would like your child to receive all preventive services offered you will need to fill out the form below and turn it back into your child's school.

Tooth decay is the #1 chronic disease in children. Dental problems make them more prone to other illnesses and infections. Prevention is key!

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 (Center for Disease Control) sealants prevent cavities by up to 80%! Toothsavers follows CDC guidelines for infection control and takes every precaution to keep your child safe. Please fill out the information below and turn back into your child's school.

Child Name: [First]_____[MI]_____[Last]_____

Birth Date_____/_____/_____ Gender: Male/Female

Childs's School_____

********HEALTH HISTORY********

The Health Insurance Portability and Accountability Act 1996 (HIPPA) requires all health care records be kept confidential. Tooth Savers of Washington LLC adheres to all HIPAA standards and will provide Notice of Privacy Practices upon request.

Check if your child has any of the following conditions: Seizures__Cancer ___ COVID-19___ Heart Problems ____Hepatitis ____Diabetes ____ Asthma___ Tuberculosis___Silver Allergy___ Other Allergies or Medical Conditions_____

*******INSURANCE OR PAYMENT*******

-DSHS/MEDICAID/APPLE HEALTH/MOLINA(9 digit # ending in WA)_____ (your cost $0)

-OTHER DENTAL INSURANCES: Name of policyholder_____ Birthdate_____ and provide a copy of front and back of dental insurance card with this form.

By *signing below, I consent for my child to receive Toothsavers preventive oral health services.*

Patient/Parent/Guardian Information: Signature:_____

Print Name:_____ Date:_____