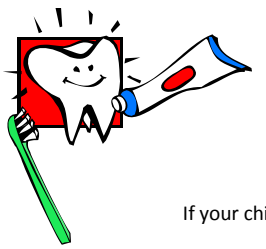

Fryeburg Family Dental

19 Portland Street, Fryeburg, ME 04037 Office: 207-256-7606

SCHOOL DENTAL HYGIENE PROGRAM

~ Patient Consent & Medical/Dental History Form ~

If your child is being seen **EVERY SIX (6) MONTHS** by a dental provider other than Fryeburg Family Dental at school, for either an exam by a dentist, dental cleaning and fillings (if needed) do not fill out this form as he/she does not qualify for the service.

Please COMPLETE ONE FORM per child – incomplete form will result in your child NOT being seen.

GENERAL INFORMATION: School Name: _____ Teacher/Grade: _____

Childs Full Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Mailing Address: _____ Town: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Other: _____

DENTAL SERVICES - Must Choose 1 Service Below that you want your child to receive:

_____ **Full Dental Cleaning, Review, and Fluoride** - Only if your child has not had a cleaning within the past 6 months.

_____ **Review** - this is an Educational Review of proper brushing, flossing & fluoride treatment (sealants placed on those with insurance if recommended) This is NOT a Dental Cleaning

INSURANCE INFORMATION: If your child does not have the following dental insurance, skip down to Uninsured/Underinsured.

Accepted Dental Insurance: **MaineCare, Guardian, NE Delta, Ameritas** (If your dental insurance is NOT listed, please contact Fryeburg Family Dental to see if accepted)

MaineCare - ID Number for Child: _____

Other - Insurance Company Name: _____ Policy Holder Full Name: _____

Policy Holder Date of Birth: _____ Group # _____ Policy/Subscriber ID: _____

UNINSURED/UNDERINSURED: These are the rates for those without the above insurance. Please send payment to school with this permission form.

☐ I would like my child to have a full dental cleaning, review, and fluoride treatment for $65.00

Method of Payment: ☐ Check #_____ ☐ Cash ☐ Money Order/Bank Check

Make checks payable to: Fryeburg Family Dental - *There will be a $20.00 fee for insufficient funds*

Make out Separate Check for Each Child being seen & write your child's Full Name in the Memo Line of your check

MEDICAL / DENTAL HISTORY:

Please list dental concerns you may have:_____

Please list any Medical Conditions your child has:_____

List ALL Medications:_____

Has your child ever needed Antibiotics for dental treatment? Y N If yes, please take the same precautions prior to treatment at school.

My child is Allergic to:_____ Physicians Name:_____

Has your child even seen a dentist? Y N Does your Child take Fluoride Supplements? Y N Do you have Town/City Drinking Water? Y N

Has he/she had a cleaning in the past 6 months? Y N If yes, was it at school? Y N Patient was last seen (month & year):_____

Patient last seen by (if was not last seen at school):_____

Please circle the services your child received during **LAST VISIT:** Cleaning - Fluoride - Sealants - Temp Filings - Fillings - Exam - X-Rays - Other:_____

Services you **DO NOT** want your child to receive from Fryeburg Family Dental, please list:_____

By signing below you are giving permission for your child to be seen up to two (2) times during this school year - approximately once every 6 months, if your child's school is able to offer two times per school year. This means your child will be added to the dental hygiene clinic schedule for the next clinic in 6 months. You will receive a reminder from the school prior to the 6 months clinic date - you are able to remove your child from the next clinic, update your child's information, etc. by contacting either FFD (207) 256-7606 or your child's school prior to the next dental hygiene clinic in 6 months.

I give permission for my child to receive dental hygiene services by a registered, independant practioner dental hygienist, at school, during school hours. I understand that Fryeburg Family Dental (FFD) may release basic information regarding services provided to benefit my child. I understand that services provided do not take the place of a complete exam by a dentist. I understand that FFD is HIPAA compliant and all records are kept confidential and that claims to insurance (if applies to your child) will go thru FFD per electronic transfer. I agree to notify my child's school and/or FFD at (207)256-7606 of ANY changes to my child's medical history or of a dental home. I also understand that all information that I have entered onto this permission form is accurate and truthful and understand that it is my responsibility to report/remember my child's date of dental service and report this date when needed for current/future dental treatment and cannot hold FFD responsible if the information is not accurate/truthful on this form regarding current and/or previous treatment/appointments with other dental office locations. I understand that if I have listed insurance information for my child & he/she does NOT have dental coverage at the time services are provided, and/or receive the same services by another dental provider within 6 months and I did not divulge this above, than I assume all responsibility for payment of services received and understand that I will receive a bill from Fryeburg Family Dental.

_____ _____ _____

Parent/Guardian Signature **Parent/Guardian Printed Name** **Date**