



9 CAREY ROAD
QUEENSBURY, NY 12804
518-764-3036
WWW.HHHN.ORG

Dear Parent/Guardian:

We are excited to be working with local schools to bring preventative dental services and dental education directly to children. If you enroll your child in the program, he/she will be seen by a NYS Licensed Dental Hygienist who will provide dental care and education that promotes healthy teeth and gums. Services include screening, cleaning, fluoride, sealants, education and referral for additional treatment if necessary. Upon completion of care, each child will receive an Oral Health Report Form indicating services provided.

All are welcome! If your child currently sees a dentist, he/she is still welcome to participate. We ask that you provide the information about your current dental provider on the consent form where indicated. Services will not be duplicated.

Families are not charged for services, only insurance companies if applicable. If you have dental insurance, we ask that you provide the insurance information to us. If your child does not have dental insurance, all services will be provided at **no cost**.

Instructions:

To participate, please complete the front and back of the enclosed form and return to your child's school. If your child will NOT be participating in the program, please indicate this and return the form to their school.

Dental Emergencies:

If your child has a dental emergency at any time of the day or night, call the office of his/her regular dentist if applicable. If your child does not have a regular dentist, call the Hudson Headwaters Dental Services Center at 518-623-3918.

To learn more about this program visit us online at www.hhhn.org or contact:

Piperlea Chico, RDH- (518) 764-3036

School Based Dental Program Director,
Dental Hygienist

Stephanie Pollak, RDH- (518) 764-8034

School Based Dental Program Dental Hygienist

Dental FAQs and Tips:

What are sealants?

- Sealants are a thin plastic coating painted onto the chewing surfaces of permanent teeth. They provide protection for your child's teeth by acting as a barrier to prevent cavities from damaging the teeth. Sealants can be applied by the Dental Hygienist.

What is Fluoride?

- Fluoride is a naturally occurring mineral. It is present in drinking water at varying levels.
- Fluoride varnish is different. It is painted on the teeth. It is quick and easy to apply and **does not** have a bad taste.

Brushing Tips

- Your child should always use a soft-bristled toothbrush.
- Toothbrushes should be replaced every **three** months.
- **Never** share a toothbrush. This can spread germs.

Flossing Tips

- Flossing cleans between the teeth where a toothbrush can't reach.
- Your child can begin flossing when any two teeth touch.

Hudson Headwaters Healthy Smiles Consent Form

Yes, I give permission for my child to be enrolled in the school based dental program.
Fill out the form in its entirety and return to your child's school.

No, I do not give permission for my child to be enrolled in the school based dental program.
Fill in your child's name, school name, sign on reverse, and return to your child's school.

1. Demographic Information

Child's First and Last Name _____ Date of Birth _____ Sex _____

Race (check one):

White American Indian or Alaskan Native Black or African American Hispanic or Latino
 Asian or Native Hawaiian/other Pacific Islander Multiracial Other:

Name of School _____ Teacher _____ Grade _____

Child's Address _____ City, State, Zip _____

Parent Guardian Name (s) _____ Email Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

2. Alternative Emergency Contact

Name _____ Relationship to Child _____

Home Phone _____ Cell Phone _____

3. Dental Coverage

___ My child has never seen a dentist.

___ My child does NOT have a regular dentist at this time. Do you need help finding a dentist for your child? ___ Yes ___ No

___ My child has been to a dentist for a cleaning within the last 6 months.

Date of last dental visit: _____ Date of next scheduled cleaning: _____

Dentist Name _____ Phone _____ Address _____

4. Dental Insurance Information

Uninsured (no dental coverage)

Medicaid Insurance _____

ID# _____ CIN# _____ SEQ# _____

Private Dental Insurance _____

ID# _____ Group# _____

Plan Name _____ Employer _____ Insurance Phone # _____

Policy Holder Name _____ Social Security Number _____ DOB _____

FOR OFFICE USE ONLY:

REVIEWED BY: _____ DATE: _____

PLEASE COMPLETE FRONT AND BACK OF FORM AND RETURN TO SCHOOL.

5. Health Information								
AIDS/HIV	Yes	No	Asthma	Yes	No	Birth Defects	Yes	No
Bleeding Disorders	Yes	No	Congenital Heart Disease	Yes	No	Diabetes	Yes	No
Fainting Spells	Yes	No	Epilepsy/Seizures	Yes	No	Rheumatic Fever	Yes	No
Heart Murmur	Yes	No	Hearing Loss	Yes	No	Kidney Disease	Yes	No
Heart Disease	Yes	No	GI Problems	Yes	No	Tuberculosis	Yes	No
Hepatitis/Liver Disease	Yes	No	Immune Deficiency	Yes	No	Vision Problems	Yes	No
Venereal Disease	Yes	No	High Blood Pressure	Yes	No	Low Blood Pressure	Yes	No
Psychiatric Disorders	Yes	No	Artificial Joints	Yes	No	Surgery	Yes	No
Hospitalization	Yes	No	Serious Injuries	Yes	No	Pregnancy	Yes	No
Comments:								

Does your child take a fluoride supplement? (please circle)

Yes	No
Yes	No

Does your child take any medication on a DAILY basis? (please circle)

Please list daily medications: _____

Does Your Child have any allergies to the following items? (please circle)

Yes	No
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Latex Tree Nuts Seasonal Resins Foods Antibiotics Penicillin Other: _____

6. Consent To Participate
<ul style="list-style-type: none"> I consent to my child receiving the following dental services: assessments, cleanings, fluoride, and sealants. I understand that this consent may stay in effect for one (1) school year while my child attends this school; however this consent may be revoked by me or my designee at any time except to the extent that the person/ organization has already acted. It is the parent/guardian's responsibility to inform the dental provider and/or the school nurse of any changes in their child's medical information. I understand that a copy of my child's dental report may be given to the school nurse or designated site coordinator and that all information about my child will be kept confidential within the Partnering Agencies. If I have dental insurance, I authorize my insurance carrier to be billed for any services provided. I have been given a copy of the Hudson Headwaters Notice of Privacy Practices and Patient Bill of Rights. I understand that Hudson Headwaters Health Network may use my child's health information for treatment, payment, health care operations, and program evaluation. I understand that it is my responsibility to keep my child's dentist informed of services provided to my child by this program to avoid duplication of services which may result in me receiving a bill from my child's dentist. I understand that Hudson Headwaters Health Network may share information regarding my child's dental visit with my child's current dental provider (if one is listed on the consent). I have read and understand the dental program and I consent to have my child participate in the school based dental program.

Signature of Parent or Legal Guardian

Printed Name of Parent or Legal Guardian

Relationship to Child

Today's Date