CONSENT FOR DENTAL HYGIENE SERVICES

Advantage Dental wants to help keep your community cavity-free and healthy. Dental hygienists from Advantage Dental will be available on site during the year to provide free dental services. These services do not replace regular dental care from a dentist.

PATIENT INFORMATION

Patient's Name: ____________________
Last Name | First Name | Middle Initial | Date of Birth

Address / City / State / ZIP: ____________________

Best phone number to reach you during the day: ____________________
Friend or family member's phone number to reach you in case you change your phone number: ____________________

Grade: **School:**

Gender: ☐ M ☐ F ☐ Other ☐ Choose Not to Disclose

INITIAL ON YES or NO to receive each service and SIGN and DATE below.

Service		
Screening (Teeth Check-up)	YES	NO
Fluoride Coating	YES	NO
Sealant	YES	NO
Silver Fluoride	YES	NO
Antiseptic for the Teeth (Iodine)	YES	NO
Protective Restoration	YES	NO

List medications currently taking: ____________________

☐ Iodine Allergy
☐ Shellfish Allergy (shrimp, crab etc.)
☐ Other Allergies (please list): ____________________

History of:
☐ Diabetes
☐ Asthma
☐ Tobacco Use
☐ Behavioral Considerations (please describe):

Other (please describe): ____________________

If you have questions or would like more information about the services provided, please call 1-866-268-9631.

Your signature indicates that you have been informed of the risks and benefits of treatment, your questions have been answered, and that you consent to the treatment indicated above.

As the parent/legal guardian, I agree to all of these statements:

- I give consent for dental services initialed/indicated above from Advantage Dental Clinics and Advantage Dental Group, PC (jointly "Advantage Dental"), and/or one of its representatives.
- The results of the oral hygiene services, including personal health information and scheduling information, may be shared between Advantage Dental, the dental provider (hygienist or patient's dentist), the community site, any listed insurance carriers, the dentist of record, any applicable Coordinated Care Organization, and/or the Dental Care Organization of record for purpose of treatment, payment or healthcare operations.
- I have been given a copy of the "Notice of Privacy Practices" and HIE (Health Information Exchange) Notification.
- This consent will remain active for 24 months unless revoked in writing or by calling an Advantage Dental representative.

If you have dental insurance through Medicaid, the Oregon Health Plan or Healthy Kids, the hygienist will notify the plan of the services received.

Print Parent/Legal Guardian Name: ____________________ **Relationship:** ____________________

Parent/Legal Guardian Signature: ____________________ **Date:** ____________________

Once Printed: Don't forget to initial yes or no options above

ONLY FILL OUT FOR KINDERGARTEN OR CHILD UNDER 7 yrs FIRST YEAR ENROLLED IN ANY SCHOOL

Dental Screening Certification Form

State law now requires a child who is 7 years of age or younger to have a dental screening before entering school for the first time. *HB 2972 (2015)*

IF YOUR CHILD HAS ALREADY RECEIVED A DENTAL SCREENING

Parent/Guardian:

- If you know your child has already had a dental screening, please check the box below, fill out this section, and sign it.
- If you do not know if your child has had a dental screening, please have a dental provider fill out this section and sign it.
- Please return this form to the school office.

☐ My child____has received a dental screening.
(First name) (Middle initial) (Last name)

Parent/Guardian or Dental Provider

Print Name: ✍ ___________________________________

Signature ✍ ____ Date ✍ _______

TO OPT-OUT OF THE DENTAL SCREENING REQUIREMENT

Parent/Guardian: You may choose to have your child opt-out of a dental screening due to a reason listed below. Please fill out this section and sign it. Then return this form to the school office.

My child ____was not screened due to the following:
(First name) (Middle initial) (Last name)

Please check all that apply:

☐ We already submitted a certification form at a previous school.
☐ The dental screening is contrary to student or families religious beliefs.
☐ The dental screening is a burden.

The dental screening is a burden for the student or the parent or guardian of the student when:

(A) The cost of obtaining the dental screening is too high;
(B) The student does not have access to a screener or;
(C) The student was unable to obtain an appointment with a screener

Parent/Guardian

Print Name ✍: ____

Signature ✍ ____ Date ✍ _____________