

Dear Parent or Guardian:

Your child may be eligible to participate in a Dental Hygiene Program at school. If your child is not currently established with a dentist they may be seen by a Registered Maine Dental Hygienist. This program is held during school hours. Please return signed permission slip and brief medical history to participate.

We provide ***cleanings, sealants, oral inspections, oral hygiene instructions and temporary fillings***. A report will be sent home with your child concerning our findings.

This ***Confidential*** program is provided to children who have current Maine **Care** numbers, ages 20 and under. Others without Maine Care may self pay on the day of service. Cleaning and fluoride treatment ages 12 and under is \$42. Cleaning and fluoride ages 13 to 20 is \$52.

Patients in the program will be seen for about 30 minutes, one to two times a year to receive this care. Only individuals with a *completed and signed permission slip* will be seen; **if there are medical changes this school year, please notify us and the school nurse!!**

If you would like your child to participate in this program, please complete the form at the bottom of the page and return it to your school. You may call **SMILE PATROL** at 717-8272 or SMILEPATROL@hotmail.com with questions or if you wish to self pay on day of service.

School Name _____ Grade _____ Male or Female

Child's Name _____

Maine Care # _____ Date of Birth - - -
(No other insurance accepted)(If you have other insurance than MC, you must self pay)

Address _____ Town _____ Zip code _____

Phone Number: _____ cell: _____ work: _____

Current Medication or Medical concerns: _____

Allergies _____

Has your child taken an antibiotic before dental treatment in the past? _____

Heart Condition _____ Heart murmurs _____ mitral valve prolapse _____

Physician's Name: _____

My child currently sees a dentist or hygienist? (Y) (N) **Date** of last visit ____-____-____ **Location:** _____

Name of dentist: _____

Services received at last visit (circle) cleaning, fluoride, sealants, temporary filling other. Do you have any dental concerns? _____

Yes, I give permission for my child to receive the dental preventive services listed above. I understand that services provided do not take the place of an exam by a dentist. I understand Smile Patrol is HIPPA compliant, all records are kept confidential and all insurance claims will go directly through Smile Patrol per electronic transfer. **I agree to notify the school nurse of any changes to my child's Medical History.**

Please sign here _____ Date _____

Please print your name _____