TOGETHER FOR HEALTH DENTAL CENTER

WAYNE MEMORIAL COMMUNITY HEALTH CENTERS
*A Clinical Affiliate of Wayne Memorial Health System, Inc.*

**School Based Dental Program**

Dear Parent / Guardian:

Wayne Memorial Community Health Centers, in conjunction with Western Wayne School District, is pleased to announce a mobile dental outreach program, which will be coming to your child's school. The Western Wayne School District has graciously agreed to partner with Wayne Memorial Community Health Centers, to make dental services accessible to our outlying communities. This program will be staffed by Lori Wood, a Registered Dental Hygienist with Together for Health Dental Center, who has received specialized training and earned additional certifications as a Public Health Dental Hygiene Practitioner and a Community Dental Health Coordinator. Lori may be accompanied by a dental assistant. Lori is highly qualified to perform dental hygiene services, as well as perform basic screenings to determine whether any follow-up care will be necessary.
**This visit will also satisfy the mandated dental screening for students in kindergarten, 3rd or 7th grade**

Research shows that early preventive dental care is the key to a lifetime of healthy teeth. This program of regular cleaning and sealants is designed to help you get your children off to a great start and detect problems before they become serious.

**This program is not designed to replace your child's regular dental visits or to interfere with the treatment plans prepared by your child's current dentist**. **It is designed to ensure that dental care is accessible to all children, especially those who do not have regular contact with a dentist or hygienist**. Your child should see their dentist for a complete exam and or additional x-rays as often as recommended by their own provider.

The services provided will be limited to those detailed on the attached consent form. Whenever your child is seen by the Dental Hygienist you will receive information on your child's oral health status as well as a list of the services provided during the visit.

Cost: The value of this service is more than $150 per child and we rely on dental insurances to help cover the costs. Please provide your dental insurance information on the attached information form.

**Enrollment:** All students can enroll in this School Based Program. Please complete the attached enrollment and consent for release of information form. **If you have any questions about the program please contact Lori Wood, RDH, PHDHP, CDHC at Together for Health Dental Center (570)251-6534.**

☐ YES I do want my child to participate with the school dental program

☐ No I do not want my child to participate with the school dental program

***Please return the completed form to your child's school nurse by*** **October 25, 2024**

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# WAYNE MEMORIAL COMMUNITY HEALTH CENTERS

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| **School Based Dental Program – satisfies the mandated dental screening for students in kindergarten, 3rd or 7th grade** | | | |
|---|---|---|---|
| Students Name | Birth Date | ☐ Male ☐ Female | |
| Address | City | State | Zip |
| School:<br>☐ Evergreen ☐ High School ☐ Middle School ☐ RDW | Teacher | Grade | |
| Parent/Guardian Name | Phone | | |
| Email | Alt. Phone | | |

**IMPORTANT HEALTH QUESTIONS:**

Does your child have any **serious health conditions** or has he/she been under the long-term care of a health care provider? **YES or NO** If YES, please explain:

Have you or your child ever been advised by a dentist or a health care provider to have your child **take antibiotics before dental treatment**? **YES or NO**

Does your child take any **daily medications**? **YES or NO** If YES, please explain:

Is your child **allergic to any medications**: **YES or NO** If YES, please explain:

**If your child has Medicaid/PA Chip Dental Insurance Information:** circle one below
**GHP Family** **Health Partner Plans** **AmeriHealth** **UMPC** **CHIP** **PA Medical Assistance**
**Dental Insurance ID #:**_____ Other_____

**Private Dental Insurance:**
**Insurance Company Name**:_____**Member ID #**:_____
**Insured Adult Name**:_____**Insured Adult Birth Date**:_____/_____/_____
Group #:_____Ins. Phone #:_____**Insured Adult SS #:**_____

**If Child Has NO Dental Insurance:**
Reduced Fees: ☐ Yes, I would like to be contacted about the sliding fee program.
☐ No, I would not like to be contacted about the sliding fee program.

AUTHORIZATION FOR PAYMENT OF SERVICES

I, the undersigned, hereby grant permission to release my dental information and to authorize payment of dental insurance benefits to Wayne Memorial Community Health Centers. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I understand that I am fully responsible for payment of all deductibles, co-insurances and co-pays.

I understand that my signature gives consent for the hygienist to provide dental services for my child and to communicate with my child's primary dental care provider. I give permission to call my home, leave a message on a machine or with a person regarding health care information, and may also mail dental care information to my home. I understand that my child's dental information will be used for treatment and health care operations.

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

I understand and authorize Wayne Memorial Community Health Centers, its affiliated dentists or dental hygienists, to provide dental services at school to the above named child for whom I am the custodial parent or legal guardian. Services may include: dental cleaning, fluoride treatment, dental x-rays, sealants and if needed, a referral to your family dentist for dental evaluation, treatment or emergency care. This hygiene service does not include an examination by a dentist. This does satisfy the mandated dental screening for students in kindergarten, 3rd or 7th grade.

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