



Healthy Smiles
Plumas County Public Health Agency
270 County Hospital Road #206
Quincy, California 95971
1-800-801-6330; 283-6330

ORAL HEALTH PROGRAM

Dear Parent/Guardian,

With your permission, your child may receive sealants and/or fluoride varnish at NO COST to you! We work with licensed dental and medical professionals from our area to provide these services. The value of this free service is \$50.00 per tooth sealed, and \$50.00 per fluoride varnish.

Name of Child _____ Date of Birth _____

Mail Address _____

Email Address _____ Day Phone _____

I want my child to have an oral health screening, sealants, and fluoride varnish. ALL

I do not want my child to receive any of these services.

I need more information.* my child sees dentist regularly. I am not comfortable with services.

*For more information contact Dana Krinsky at 283-6358.

Child's Regular Dentist _____, or no regular dentist

NO PAYMENT IS REQUIRED from you for this service. For program information purposes, please check the insurance you have. Billing Medi-Cal helps cover the cost of our program.

Medi-Cal: Child's Medi-Cal Number _____

Other Insurance/Describe _____ Self-Paid or Employer Paid

No Dental Insurance

Yes. Photograph Release: I grant permission to the Healthy Smiles/Plumas County Public Health Agency to use my child's photograph in any official outreach publications and displays without compensation to me or my child.

I give permission for my child to receive dental services at school through Healthy Smiles and its affiliates. I understand that Healthy Smiles is HIPPA compliant and all records are kept confidential. I authorize the gathering and sharing of information between Healthy Smiles, its affiliates, my child's dentist, and insurance, I have read and completed both sides of this form and understand this permission may include a follow-up visit.

Parent/Guardian: _____
(Print Name) (Signature) (Date)

Teacher _____ Room _____ Grade _____

TURN PAGE OVER
Complete other side

Child's Ethnicity (Check all that apply) White Black/African American Asian Hispanic
 American Indian/Alaskan Native Native Hawaiian/Pacific Islander Other

Male Female **Home Language:** English Spanish Other _____

MEDICAL HISTORY

Respond to each question by checking the yes or no box.	YES	NO	Notes/Explain
1. Is your child taking medications? If yes, what medications?			
2. Does your child have allergies? If yes, to what?			
3. Does your child need to take antibiotics before having dental care because of health problems. If yes, explain.			
4. Does your child have any problems requiring special dental services?			
5. Please put an (x) if your child has ever had any of the following: <input type="checkbox"/> Hepatitis <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Epilepsy <input type="checkbox"/> Asthma <input type="checkbox"/> Seizures/convulsions			

***Parent volunteers are needed.**
Please check if you are willing to volunteer for this event at your child's school. Yes

DDS/RDH _____	For Office Use Only	ID _____
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Screening = 0 **D** = Decay **F** = Filled **M** = Missing **SDF** = Silver Diamine Fluoride
DATE _____ **S** = Sealant Present **PS** = Prescribe Sealant **RS** = Recommend Reseal

<i>Tooth #</i>	1	2	3	4 - A	5 - B	6 - C	7 - D	8 - E	9 - F	10 - G	11 - H	12 - I	13 - J	14	15	16
<i>Code</i>																
<i>Tooth #</i>	32	31	30	29 - T	28 - S	27 - R	26 - Q	25 - P	24 - O	23 - N	22 - M	21 - L	20 - K	19	18	17
<i>Code</i>																

Comments: No Decay Early Decay Moderate Decay Urgent Decay

II. Preventive Services DATE _____ DATE _____

Healthy Smiles Provided	1 = No Treatment 2 = Varnish	Licensed Treatment Provided	3 = Prophy 4 = Sealants (# retained) _____ / (# provided) _____ 5 = SDF
Applied By:		Applied By:	
Referral to: <input type="checkbox"/> Medi-Cal Provider <input type="checkbox"/> Dental Home		Date: _____	

Comments:

III. Site Follow-Up DATE _____ DATE _____

Healthy Smiles Provided	1 = No Treatment 2 = Varnish	Licensed Treatment Provided	0 = Visual Screening Follow-Up <input type="checkbox"/> No Decay <input type="checkbox"/> Early <input type="checkbox"/> Moderate <input type="checkbox"/> Urgent <input type="checkbox"/> Restorative treatment noted 3 = Prophy 4 = Sealants (# retained) _____ / (# provided) _____ 5 = SDF
Applied By:		Applied By:	
Patient did not receive follow-up sealants due to: <input type="checkbox"/> active decay <input type="checkbox"/> sealants present <input type="checkbox"/> student absent			

Comments: