

CELEBRATE SMILES

A community collaboration ensuring
all children have healthy teeth



The Celebrate Smiles program, operated by Access Community Health Centers, will soon be at your child's school. Dental screenings and treatment will take place in a one to two week period, and may include a follow-up visit later in the school year to check on previous work, or for a second fluoride varnish treatment, or additional dental treatment if needed. **Please fill out the front and back of this form,** check yes and sign below so that your child may participate in this program and receive dental services at school. After our dental staff care for your child, we will send home a written summary of services with your child.

Please complete all the information to participate in the Celebrate Smiles preventive program:

YES, I would like my child to receive dental services through the Celebrate Smiles program.

NO, I don't want my child to receive dental services through the Celebrate Smiles program.

(If no, please fill out only name and grade.)

School: _____ Teacher: _____ Grade: _____

Child's Name: _____ Birthdate: _____ Male Female

Address _____ Telephone: _____

City _____ Zip: _____

Ethnicity (select one): Hispanic Non-Hispanic Unknown

Race (select one): White Black/African American Asian American Indian/Alaska Native

Native Hawaiian/Pacific Islander Unknown/Not Available

What is your annual income? _____ What is your family size? _____

By checking yes above, I give my consent for my child to receive a dental screening and the procedures listed below (if necessary) at school. The screening and procedures will be provided by the Celebrate Smiles dental staff, from Access Community Health Centers. **Procedures could include:**

- **Dental cleaning:** Removing cavity-causing film stuck on teeth.
- **Dental sealants:** Thin plastic coatings put on teeth to protect them from cavities.
- **Fluoride varnish:** Coating brushed on teeth to help protect them from cavities.

Consent must be signed by parent or legal guardian.

Name of Parent or Guardian (please print clearly): _____

Signature: _____ Date: _____

This consent will be valid for one year from the date of signature.



Please fill out the reverse side



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Health History

Allergies your child has _____ None

Medication your child is taking _____ None

Does your child have asthma? YES NO

Does your child have any congenital heart defects that have not been fixed or outgrown? YES NO

Does your child have any other health issues? YES NO

(If yes, please list here): _____

Does your child need or use more medical care than other children the same age? YES NO

Does your child have trouble doing things most children the same age can do? YES NO

Does your child need or get special therapy, such as physical therapy, occupational therapy or speech therapy? _____ YES NO

Does your child need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking or other activities? YES NO

If you answered yes above, has this problem lasted or is it expected to last at least 12 months? YES NO

Does your child have a regular dentist? YES NO

(If yes, please provide name here): _____

Medical Assistance/BadgerCare or Dental Insurance

Does your child have Medical Assistance/BadgerCare?

NO YES If yes, list the child's Medicaid number ID _____

Does your child have other dental insurance?

NO YES If yes, list the child's dental insurance information:

Dental Insurance Company _____ Subscriber Name: _____

Effective Date of Insurance: _____

Insurance Company Address: _____

Subscriber Date of Birth: _____ Subscriber Social Security # _____

Subscriber ID or Member # _____ Group # _____

Private insurance and Wisconsin Medicaid/BadgerCare will be billed for services provided to children who have coverage. I authorize Access Community Health Centers and any dentist involved in my child's care to release to the Wisconsin Medicaid Program and their agents or other dental insurance company the medical information necessary to obtain approval for payment for care or to process claims. I further authorize payment of any Medicaid or other dental insurance benefits directly to the Access dentist involved in my child's care.

NOTICE OF PRIVACY PRACTICES: Access Community Health Centers' Notice of Privacy Practices is available online at accesscommunityhealthcenters.org, and with the Celebrate Smiles program for review at your request.

Questions? Call Access Community Health Centers' Celebrate Smiles Team at (608) 852-2781.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Huru 1-608-443-5480 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-443-5480 (TTY: 711).