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 over a one to four week period. Treatment may include follow-up visits over the next 18 months to check on previous work, for a second fluoride varnish treatment or to provide additional dental treatment. **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 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: _____ Email: _____

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

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, led by a licensed dentist 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.
- **Extraction:** Removing a tooth.
- **Fluoride varnish:** Coating brushed on teeth to help protect them from cavities.
- **Fillings:** Removing the portion of a tooth with a cavity and then putting a filling in that area.
- **Pulpotomy:** Removing deep cavities in the middle of a tooth and putting a filling in that area.
- **Local anesthetic:** Medicine that makes the mouth numb and is used during some dental treatments to prevent discomfort or pain.
- **Stainless steel crown:** Removing severe decay from tooth and placing a metal cap on it.

☐ **Contact me about my child's treatment.**

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 18 months from the date of signature, or until another form is signed.

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? (Insurance will be billed for treatment.)

☐ 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. Hurau 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).