Patient Name:

DOB:

MR #:

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Date: _____

Access Community Health Centers
2901 West Beltline Highway, Ste 120, Madison, WI 53713

CELEBRATE SMILES CONSENT FOR DENTAL TREATMENT

Celebrate Smiles
Access Community Health Centers

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 treatment or to provide more dental care.

Check yes below and sign on the last page if you want your child to participate in this program and receive dental services at school. Our dental staff will send home a written summary of services provided for your child.

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: Fluoride releasing plastic coating 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.
- Local anesthetic: Medicine that makes the mouth numb and is used during some dental treatments to prevent discomfort or pain.
- Silver Diamine Fluoride (SDF): A topical medication used to treat and prevent cavities.
- Space Maintainer: A space holder used in between teeth after baby teeth are lost early to make space for permanent teeth.

Please complete all the information to participate in the Celebrate Smiles program. Please fill out the **front and back** of this form.

☐ **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 below)

School: _____ Teacher: _____ Grade: _____

Child's Name: _____ Birthdate: _____

☐ Male ☐ Female ☐ Nonbinary ☐ X

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

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

Please fill out the back side.

Patient Name:

DOB:

MR #:

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Access Community Health Centers
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CELEBRATE SMILES CONSENT FOR DENTAL TREATMENT

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 #: _____

If your child is covered by Wisconsin Medicaid/BadgerCare and/or other insurance, Access Community Health Centers will bill that insurance plan and/or Wisconsin Medicaid/BadgerCare for services provided to your children. Access will not bill you. I consent to Access Community Health Centers and any dentist involved in my child's care to release (share) to the Medicaid Program and their agents or other dental insurance company the information necessary to obtain approval for payment for care or to process claims. I authorize payment of any Medicaid or other dental insurance benefits directly to the Access dentist involved in my child's care.

This consent will be valid for 18 months from the date of signature, or until another form is signed.

AUTHORIZING SIGNATURES:

Signature of Patient/Representative: _____ Date: ____/____/____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is: ☐ Minor ☐ Incompetent / Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other: _____

Provider Signature*: _____ Print Provider Name*: _____

Date: _____/_____/_____ Time: _____ Pager#: _____

_____ _____
Interpreter or Reader Signature (if applicable) Witness Signature**

_____ _____
Print Interpreter or Reader Name Print Witness Name

_____/_____/_____ _____ _____/_____/_____ _____
Date Time Date Time

* Provider can be Dentist or Dental Hygienist performing services.
** Only required if patient signature not obtained by provider or when telephone consent obtained.

NOTICE OF PRIVACY PRACTICES: Access Community Health Centers' Notice of Privacy Practices is available 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) 443-5482 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hurau 1-608-443-5482 (TTY: 711).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-443-5482 (TTY: 711).