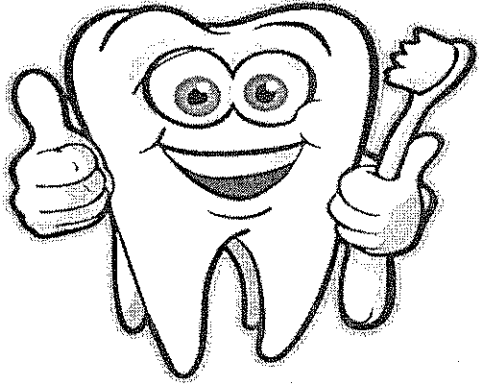


SCHOOL DENTAL PROGRAM



- Dental Cleaning
- Fluoride Treatment
- Visual Examination
- Oral Hygiene Instruction
- Dental Sealants (if needed)

Sign up today!

Just complete the attached registration form and return to the school nurse by December 16th. Your child will then be seen at school for a dental cleaning twice during the current school year.

We submit to most insurance companies. Husky/Medicaid covers 100%. For uninsured students we have a discounted rate of \$30.00 for dental cleaning and \$12.00 for dental sealants (if needed)

If you have any questions please contact the Dental School
Coordinator: Lori A. Sanford at (860) 528-1359 x183

East Hartford Community HealthCare, Inc., 94 Connecticut Blvd, East Hartford, CT 06108
Manchester Community HealthCare, Inc., 140 North Main Street, Manchester, CT 06042
Vernon Community HealthCare, Inc., 3 Prospect Street, Vernon CT 06066

*****Informed Consent and Medical History Form*****

East Hartford Community Healthcare, Inc. School-linked Dental Program

Dear Parent/Guardian:

The school-linked dental program can provide the following services in your child's school, during school hours: **a cleaning, visual screening exam, and fluoride treatment as part of the visit along with proper brushing and flossing instructions.** X-rays will not be taken.

If you wish your child to receive dental treatment at school, please answer all the questions and sign the form. Return this form to the school.

Child's Name _____ Gender M F Room _____ Birthdate _____

Parent/Guardian _____ Address: _____ ZIP: _____

HomePhone# _____ Work# _____ Cellular # _____

Emergency Contact: _____ Phone: _____

Child's Dental Insurance Plan _____ Parent's Birthdate _____

Please send a copy of the insurance card

Child's Insurance Number (#)/ I.D. _____ Group # _____

Insurance Policy Holder Name _____ Policy Holder Birthdate _____

Social Security Number (#)(Child) _____ (Parent) _____

Race: Black White Asian Native Hawaiian Unreported/Refuse to report Other _____

Ethnicity: Hispanic/Latino Yes No

MEDICAL HISTORY

Name of medical doctor or clinic where child gets care _____ Phone # _____

Does your child have any of the following?	CHECK YES/NO	Explain "Yes" answers:
Heart Condition?.....	Y N	_____
Heart Murmur?.....	Y N	_____
Allergies?.....	Y N	_____
To medications?.....	Y N	_____
To latex materials?.....	Y N	_____
Asthma?.....	Y N	_____
Seizures?.....	Y N	_____
Any infectious diseases?.....	Y N	_____
Sickle Cell Anemia?.....	Y N	_____
Diabetes?.....	Y N	_____
Problem with bleeding?.....	Y N	_____
Any other medical problem not listed?.....	Y N	_____
Does your child take any medications?.....	Y N	What? _____

Please let the dental office know if there are any changes in the above information.

PERMISSION FOR TREATMENT and HIPAA ACKNOWLEDGEMENT

I give my permission to do a cleaning, visual screening exam, oral hygiene instructions and fluoride treatment every 6 months, and sealants as necessary. *I also give permission to obtain/release information regarding treatment and/or services to insurance providers and the school nurse. Also, I understand that there is \$30 charge for the cleaning and fluoride treatment and \$12 per sealant if my child does not have insurance.* I acknowledge that I have received a copy of the Notice of Privacy Practices for East Hartford Community HealthCare, Inc.

SIGNATURE _____ DATE _____

Parent/Guardian