CLASSROOM DENTAL CONSENT FORM

Best Dental Help
Educate, Brush, Floss, Fluoride, Seal, Refer

Child's FULL Name: _____ Gender: M F Date of Birth: ___/___/_____
first *last* *mm dd yyyy*

School: _____ Classroom/Teacher (circle one): _____ AM PM Full Day

Best Dental Help is a nonprofit Oral Health Program. Our mission is to PREVENT dental decay in children. Your child's school has decided to include Oral Health Education in their curriculum. With your permission, a **Dentist or Dental Hygienist will screen your child's teeth to check for tooth decay and may apply fluoride varnish**. These services are proven to prevent cavities. Results of your child's screening will be given to the parent on the day of the screening. This service is at **NO COST** to you or the school. This does not replace a comprehensive dental visit recommended twice a year, but is a great introduction to dental care by a professional team. This program is offered to all children, especially for those who otherwise would have difficulty with access to dental care.

My child has a Provider One card (Medicaid/Apple Health/DSHS). Please provide the following information for billing purposes. ___ ___ ___ ___ ___ ___ ___ ___ ___ WA

Questions: Please contact Lauren Bursell, CEO Lauren@BestDentalHelp.org or (206) 403-5081.

DENTAL SCREENING CONSENT (CHECK ONLY ONE)

☐ **YES,** I want my child/student to participate in this preventative Oral Health Program. The services include **oral screening/assessment, oral health education/instruction, and fluoride varnish.**

☐ **YES,** I want my child to participate, but **please do NOT apply fluoride varnish.**

☐ **NO,** my child/student receives regular dental care from our Dentist.

Parent/Guardian Signature: _____ Date: ___/___/_____
mm dd yyyy

Parent/Guardian Name (please print): _____

Child's Health History:

Does your child have any allergies? ☐ Yes ☐ No If yes, please list. _____

Does your child have any serious medical conditions? ☐ Yes ☐ No If yes, please list. _____

Concerns I have about my child's teeth or anything you would like us to know before we screen him/her:

_____

_____

Please note that all personal information is private and protected by the HIPAA Act of 1996. A complete copy of our privacy is available upon request.

For more information visit www.bestdentalhelp.com

OFFICE USE ONLY
ABS MOV REF
Date: _____
Initials: _____

Revised 05/19