Healthy Smiles
Plumas County Public Health Agency
270 County Hospital Road #206
Quincy, California 95971
1-800-801-6330; 283-6330

ORAL HEALTH PROGRAM

Dear Parent/Guardian,

With your permission, your child may receive sealants and/or fluoride varnish at NO COST to you! We work with licensed dental and medical professionals from our area to provide these services. The value of this free service is $50.00 per tooth sealed, and $50.00 per fluoride varnish.

Name of Child_____ Date of Birth_____

Mail Address_____

Email Address_____ Day Phone _____

I want my child to have ☐ an oral health screening, ☐ sealants, and ☐ fluoride varnish. ☐ ALL

I do not want my child to receive any of these services. ☐

☐ I need more information.* ☐ my child sees dentist regularly. ☐ I am not comfortable with services.

*For more information contact Dana Krinsky at 283-6358.

Child's Regular Dentist_____, or no regular dentist ☐

NO PAYMENT IS REQUIRED from you for this service. For program information purposes, please check the insurance you have. Billing Medi-Cal helps cover the cost of our program.

☐ **Medi-Cal: Child's Medi-Cal Number**_____

☐ **Other Insurance/Describe**_____ ☐ **Self-Paid o**r ☐ **Employer Paid**

☐ **No Dental Insurance**

☐ Yes. Photograph Release: I grant permission to the Healthy Smiles/Plumas County Public Health Agency to use my child's photograph in any official outreach publications and displays without compensation to me or my child.

I give permission for my child to receive dental services at school through Healthy Smiles and its affiliates. I understand that Healthy Smiles is HIPPA compliant and all records are kept confidential. I authorize the gathering and sharing of information between Healthy Smiles, its affiliates, my child's dentist, and insurance, I have read and completed both sides of this form and understand this permission may include a follow-up visit.

Parent/Guardian: _____ _____ _____

(Print Name) *(Signature)* *(Date)*

Teacher_____Room_____Grade_____

TURN PAGE OVER
Complete other side

Child's Ethnicity **(Check all that apply)** ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other

☐ Male ☐ Female **Home Language:** ☐ English ☐ Spanish ☐ Other _____

MEDICAL HISTORY

Respond to each question by checking the yes or no box.	**YES**	**NO**	**Notes/Explain**
1. Is your child taking medications? If yes, what medications?			
2. Does your child have allergies? If yes, to what?			
3. Does your child need to take antibiotics before having dental care because of health problems. If yes, explain.			
4. Does your child have any problems requiring special dental services?			
5. Please put an (x) if your child has ever had any of the following: ( )Hepatitis ( )Rheumatic Fever ( )Heart Murmur ( )Epilepsy ( )Asthma ( )Seizures/convulsions			

***Parent volunteers are needed.**
Please check if you are willing to volunteer for this event at your child's school. ☐ Yes

DDS/RDH_____ For Office Use Only ID_____

Screening = 0
DATE_____

D = Decay **F** = Filled **M** = Missing **SDF** = Silver Diamine Fluoride
S =Sealant Present **PS** = Prescribe Sealant **RS** = Recommend Reseal

Tooth #	1	2	3	4 - A	5 - B	6 - C	7 – D	8 - E	9 - F	10 - G	11 - H	12 - I	13 – J	14	15	16
Code																
Tooth #	32	31	30	29 - T	28 - S	27 - R	26 - Q	25 - P	24 - O	23 - N	22 -M	21 - L	20 - K	19	18	17
Code																

Comments: ☐ No Decay ☐ Early Decay ☐ Moderate Decay ☐ Urgent Decay

II. Preventive Services DATE_____ DATE_____

Healthy Smiles Provided	1 = No Treatment 2 = Varnish	**Licensed Treatment Provided**	3 = Prophy 4 = Sealants *(# retained)_____/(# provided)_____* 5 = SDF
Applied By:		Applied By:	
Referral to: ☐ Medi-Cal Provider ☐ Dental Home		Date:_____	

Comments:

III. Site Follow-Up DATE_____ DATE_____

Healthy Smiles Provided	1 = No Treatment 2 = Varnish	**Licensed Treatment Provided**	0 = Visual Screening Follow-Up ☐ No Decay ☐ Early ☐ Moderate ☐ Urgent ☐ Restorative treatment noted 3 = Prophy 4 = Sealants *(# retained)_____/(# provided)_____* 5 = SDF
Applied By:		Applied By:	
Patient did not receive follow-up sealants due to: ☐ active decay ☐ sealants present ☐ student absent			

Comments: