

Please return

Voluntary School Dental Program

To: Parent/Guardian

This letter is to inform you that **your child's school** has elected to participate in a voluntary dental healthcare program. **Kintegra Mobile Dentistry** is a Mobile Dental Unit that will be at your child's school, providing dental evaluations and preventive treatment. We believe preventive dental care services are important for our children's development. Basic dental services can reduce the number of days our children suffer throughout the year due to dental related illnesses and prevent unnecessary pain and distress, which leads to good overall health and quality of life.

Tooth decay is the single most common chronic childhood disease. Children with untreated decay are less likely to reach their full potential because dental disease can affect both physical and emotional health and development.

Please find (on back) a consent form authorizing **Kintegra Mobile Dentistry** to provide a dental evaluation, x-rays, dental cleaning, fluoride treatment, and possible sealants during your child's visit. There will be **no charge** to the parent for these services. If your child has Medicaid, it may be charged, but no payment will be asked of the parent. All follow up visits will require financial or insurance documentation.

If you approve of your child's participation and want your child to receive these preventive dental services on Kintegra's Mobile Dental Unit at his/her school, please fill out the consent form (on back) completely, sign, and return to your child's school.

Best regards,



Robert Spencer
Executive Director



**Our office follows infection control recommendations made by the American Dental Association (ADA), the U.S. Centers for Disease Control and Prevention (CDC), and the Occupational Safety and Health Administration (OSHA). We follow the activities of these agencies so that we are up-to-date on any new rulings or guidance that may be issued in the future.*

**Kintegra Mobile Dental Unit has 3 HEPA UV-C air filtration systems (clean air purifiers) on board.*

**Social distancing between patients*

**Only preventive services (dental evaluation/cleaning/sealants/x-rays/intraoral photos) are performed on the mobile unit at school – No aerosols are created.*



Mobile Dentistry

Please Return

(Failure to return by specified date may result in your child not being seen)

KINTEGRA FAMILY DENTISTRY CONSENT FOR EXAMINATION AND TREATMENT

I hereby give consent for my child, _____, to have dental services on Kintegra Family Dentistry's Mobile Dental Unit. (Please print child's full name)

Home Phone: (____) - ____ - ____ | Cell: (____) - ____ - ____ | Email: _____

Address: _____ City: _____ Zip Code: _____

Child's Date of Birth: ____ / ____ / ____ | Race: B W H Other | Gender: M F

Teacher: _____ Grade: _____ | Child's Social Security Number: _____ - _____ - _____

Insurance: (Check one and provide # if applicable)

Private Dental Ins. No Dental Ins. Medicaid #: _____ Health Choice #: _____

Has your child ever been to a dentist? Yes No

If yes, what month & year was the last dental exam & cleaning? _____

Is your child having any dental **problems** now? Yes No

If yes, explain: _____

Has your child complained of anything **hurting** in their mouth? Yes No

If yes, explain: _____

Please list all **medications** your child is taking: _____

Please list all **allergies** your child has to medications, foods etc.: _____

Name of child's Physician: _____ Phone #: (____) - ____ - ____

Name of Pharmacy: _____ Did your child receive a **FLU SHOT** this year? Yes No

Please **CIRCLE** any condition your child has now or has ever had:

HEART TROUBLE

*If yes, explain: _____

ASTHMA

*If yes, date of last attack: _____

EPILEPSY, SEIZURES

*If yes, date of last seizure: _____

HEPATITIS

*If yes, circle: **A, B, and/or C**

TUBERCULOSIS (TB)

AIDS/HIV

DIABETES

ADHD

CANCER

SPINA BIFIDA

JOINT REPLACEMENT

FAINTING/DIZZINESS

SICKLE CELL DISEASE

PREMATURE BIRTH

BLEEDING DISORDER

Please list any other health problems your child has: _____

You are consenting for your child to receive the following services as found appropriate:

Dental Evaluation, X-rays, Intraoral Photos, Cleaning, Fluoride Treatment

Would you like your child to have **Sealants** placed if the provider thinks they would be beneficial? Yes No

*Sealants are a preventative white coating that covers the grooves and pits of the back teeth. This helps cavities from forming.

There is no charge to the parent while at the school. Sealants will only be done if time permits.

I understand that by signing, I am giving full consent for my child to receive the dental services listed on this form.

Name of Parent or Legal Guardian
(Please print)

Signature

Date