Gateway Oral Health Program

Preventative Dental Care

A preventative dental program provided by the Gateway District Health Department and a Public Health Registered Dental Hygienist with no-out-of-pocket expense! Your child's dental benefits remain unused and will not affect your visit with a dentist!

We are supported by the Dept of Public Health, KY Dental Director, GDHD Health Board, along with members of the local dental and healthcare community. Using our funds, grant money and Medicaid Medical Provisions allow us to provide these services to all kids for free. A licensed dentist will not be present during the screening, nor required for the PHRDH to give this service (KY Dental Practice act KRS 313.040).

Our goal is to provide preventative services to all & establish your child into local dental homes.

The **BEST** way to protect children from tooth decay is to **STOP** it before it starts. Regular dental assessments, cleanings, sealants, and fluoride are essential to building strong, healthy, beautiful teeth for a lifetime.

Our GDHD **Public Health Registered Dental Hygienist** (PHRDH) Provides:

Assessment: They will visually screen your child's teeth and assess for any possible problems.

Prophy: PHRDH will provide an age-appropriate dental cleaning

Education/Counseling: Oral health education & Nutrition counseling. Tobacco education and substance abuse counseling as needed and when appropriate (6th grade and up).

Fluoride: Fluoride Varnish is a layer of fluoride that is painted onto the teeth. It **can be applied up to six times a year**. Fluoride can prevent, slow down, and reverse the tooth decay process.

Dental Sealants as needed: Sealants are applied in the grooves of molars to prevent cavities in the chewing surfaces of your child's teeth. They can last up to 10 years. They save lots of time and money in preventing extensive dental work.

Each child will receive a toothbrush, toothpaste, and a dental report card with any finding. If dental problems are noted, a referral to a local dental home will be made along with support and resources from our program.

Only a licensed dentist may make a diagnosis of decay, PHRDH will refer for decay and support the patient/parent and help establish a dentist as needed.

Please complete the back of this form to allow your child to participate.

Gateway Oral Health Program | Gateway District Health Dept.

Phone: (606) 784-8954 ext. 3140

Brooke Jones PHRDH, BSDH | Dir. Of School Oral Health

Gateway Oral Health Program

730 W. Main Street | Morehead, KY 40351
Office (606) 784-8954 ext. 3140

CONSENT FOR DENTAL TREATMENT

***Please* Print all information on this form if you wish to participate & return it with registration forms for the school year.**

Gateway District Health Department
Bath, Elliott, Menifee, Morgan, and Rowan
P.O. Box 555 · Gudgell Avenue · Owingsville, KY 40360
(606) 674-6396 · Fax: (606) 674-3071

Child's Name: First _____ **MI** ____ **Last** _____ **Circle:** Male Female **Date of Birth:** ____/____/____

Child's Social Security Number (required): _____ **Race:** _____ **Hispanic/Latino:** Y N

Please provide **reliable** contact information where we can reach you:

Home Phone #:(____) _____ **Mobile #:** (____) _____ **Email:** _____

Parent/Legal Guardian: _____ **Relationship to child:** _____

Address: _____

City: _____ **Zip:** _____ **Preferred language:** _____

Emergency Contact Name & phone #: _____

(Please provide a separate emergency contact, other than yourself, if you cannot be reached. Please add relationship to patient)

Utilized for connection to resources: #in Household: _____ **Annual Income:** _____

School: _____ **Teacher:** _____ **Grade:** _____

DENTAL HISTORY

Has your child been seen at the same dental office twice in the past two years for check-ups? Y N **Name of dentist/office:** _____

Do you have trouble finding a dentist or need help locating a dental home? Y N **Transportation issues getting to appointments?** Y N

MEDICAL INFORMATION

Has your child ever had any of the following (if yes, please explain below): We may call for clarification on any needed information missing.

☐ Surgery- please provide info & date below.	☐ Diabetes	☐ Hearing Loss/Speech Issues
☐ Bleeding Problems	☐ Heart Murmur	☐ Heart Problems
☐ Seizures/Epilepsy	☐ Autism: Level/Severity: 1/Mild 2/ Moderate 3/ Severe	☐ ADD/ADHD
☐ Cancer/Chemo	☐ Asthma	☐ Anxiety/Fear
☐ Trauma (head, neck, mouth)	☐ Antibiotic pre-med required for dental treatment	☐ OTHER: explain

If yes, explain: _____

Allergies: _____

Daily Medication: _____

Circle all that apply: **No Insurance** **Private Dental Insurance** **Medicaid**

Medicaid ID: _____

CIRCLE MCO: AETNA ANTHEM HUMANA CARESOURCE PASSPORT/ MOLINA WELLCARE UNITED HEALTHCARE

*** **Medicaid Medical Provisions & funds are set aside for health departments. This program does not affect your dental insurance benefits or your local dental homes!!**

CONSENT FOR DENTAL SERVICES and ASSIGNMENT OF BENEFITS: I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care for my child which may include dental screening/assessments, preventative dental treatment, and any other health service provided by staff or agents of this health department. I understand that no guarantees are being made as to the effect of any preventive service provided for my child. I also understand that no x-rays will be taken and that my child may be screened to check the retention of these sealants by the public health dental hygienist the following school year. I also understand that my child may be tested for HIV, Hepatitis B, or any other bloodborne disease should a healthcare worker be exposed to blood or bodily fluids. I authorize this health department to release dental information about my child, as permitted by HIPPA to his/her primary care physician, dentist, and school staff. I authorize the release of my child's dental records to a dentist for follow-up care and establishing a dental home. This program does not take the place of regular check-ups at a dental office. The services are being provided by a Public Health Registered Dental Hygienist under protocols signed by Dr. Emily Blevins, DMD. I understand that no dentist is present or required for the PHRDH to perform the dental procedures according to the KRS 313.040 KY Dental Practice Act. **PRIVACY**: This form, when completed and signed, contains Protected Health Information which will be protected according to the Health Insurance Portabi lity and Accountability Act (HIPAA). My signature below acknowledges my understanding of Gateway District Health Department (GDHD) *"NOTICE OF PRIVACY PRACTICES"* *** *and how to receive a copy* on the date stated. I have read the above and I understand the items included in this packet as they apply to me and my child. Text messaging and email may be utilized and may contain personal health information and are not considered a confidential means of communication. The signature below indicates I do consent, authorize, and declare as stated above. Permission can be revoked at any time.

ASSIGNMENT OF BENEFITS: I request that payment of authorized insurance benefits be made to GDHD on my child's behalf, for services received. I also authorize GDHD to release oral health information about my child to Medicaid to determine Payment for services.

X _____ **Date:** _____

Parent/Legal Guardian Signature (Expires at end of the school year)

DO NOT SIGN FORM OR RETURN IF YOU DO NOT WISH TO PARTICIPATE.

*** *You can request a physical copy of our HIPAA form, view online by visiting GDHD.org, or request an emailed copy.*

"Sparkling Futures Start with A Sparkling Smile"