Dear Parents/Guardians,

Future Smiles is a dental hygiene program that focuses on dental disease prevention. Our services are provided at school-based locations serving CCSD students who are from low-income families, uninsured and/or Medicaid/CHIP enrollees. There is no fee to the child or the family for our services but we do bill Medicaid/CHIP. Your child will be seen by a dental hygienist and will receive one or more of the following preventive services: (1) dental cleaning, (2) sealant, (3) dental x-rays at limited locations and (4) fluoride varnish/topical. 6-12 month follow-up care is highly recommended!

A *dental sealant* is a thin plastic coating that fills in the deep grooves on the chewing part of the tooth. They are easy, painless and will help prevent decay as your child grows.

Fluoride varnish is a protective coating that is painted on the teeth to help strengthen the tooth structure helping the teeth to be more resistant to decay.

A *dental cleaning* removes all hard and soft material that forms on the child's teeth. Future Smiles staff will also educate your child on how to properly care for their teeth at home and make good diet choices for a healthy future.

To take advantage of this great program conducted at the school PLEASE fill out the attached consent form! This is *CONFIDENTIAL* information and will only be used to serve the needs of the community. (Please check correct answer)

1) Number of parents and children in your family: _____

2) Monthly Income: $_____

3) What school grade (K-12) did you complete? _____

4) Do you have any of the following? *Circle YES or NO response*

My child is on free and reduced lunch?	YES	NO
High School degree/GED?	YES	NO
A degree from a 2-year college?	YES	NO
A degree with 2 or more years of college?	YES	NO

5) Does your child live with the following family member(s)?
Single parent/mother _____ Single parent/father _____
Both parents _____ Other _____

6) What is your source of income?
No income _____ TANF _____ Other _____ SSI _____
Social Security _____ Pension _____ General Assistance _____
Unemployment _____ Employment +other _____
Employment only _____

7) What is your current housing?
Own _____ Rent _____ Homeless _____
Other _____

FUTURE SMILES HEALTH HISTORY/CONSENT

Future Smiles is a preventive oral health program that includes a dental cleaning, dental sealant, fluoride varnish application and limited locations may offer dental x-rays and cleanings. Eligible children are CCSD students who are 18 years and younger, uninsured or Medicaid/CHIP enrollees. All restorative dental needs will be referred to your current dental home or partnering community dental office/clinic. This is a five-year commitment to allow for continuation of care.

Please complete the following so your child can participate in the program. Return forms to your child's teacher.
***DO NOT FORGET TO SIGN.* Thank you!**

_____**YES, I authorize** a public health dental hygienist to assess the permanent molars/premolars of my child and then authorize placement of dental sealants on those teeth that are indicated by staff of Future Smiles, dental/dental hygiene students, and/or volunteer dental hygienists. I also authorize all preventive dental services to include dental cleaning (prophylaxis), fluoride varnish, CalmKIDZ™, Oraspa™ and x-rays of my child's teeth. I agree to accept appointment reminders and other messages on my phone, allow my child's image to be used by Future Smiles, to take a satisfaction survey and review of my child's CCSD data for program evaluation and promotion. I agree not to hold Future Smiles or its partners liable for any negative reactions as a result of care received for my child or myself. If applicable I approve the billing of Medicaid/CHIP for services provided.

I agree_____ to allow another agency to assist me with Medicaid enrollment and referral for dental restorative treatment.
(*Initial here for yes)*

_____**NO, I do not** want my child to receive sealants.
_____**NO, I do not** want my child to have a dental cleaning.
_____**NO, I do not** want my child to have dental x-rays.
_____**NO, I do not** want my child to take a satisfaction survey
_____**NO, I do not** want my child to experience CalmKIDZ™
_____**NO, I do not** want my child to have fluoride varnish.
_____**NO, I do not** want my child's image used by Future Smiles.
_____**NO, I do not** want messages left on my phone.
_____**NO, I do not** want my child's CCSD data reviewed.
_____**NO, I do not** want to experience Oraspa™.

Parent or Guardian: _____ **Parent or Guardian:** _____**Date:** _____
SIGNATURE (MUST HAVE THIS!!) **PLEASE PRINT NAME**

Name of child: _____ Male: _____ Female: _____ Date of Birth: _____

Home Address: _____ City: _____ Zip: _____

Parent Phone: _____ Cell Phone: _____ Texting:_____ YES _____ NO

Email: _____

School: _____ Teacher: _____ Room: _____ Grade: _____

Race:

White/Caucasian _____ African American/Black _____ American Indian/Alaska Native _____ Asian_____
Hispanic _____ Native Hawaiian/Pacific Islander _____ Mixed Race _____ Other_____

Student ID number: _____

Please answer the next questions to help us learn more about your child.

1. About how long has it been since your child last visited a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists. **(Please check one)**
6 months - 1 year ago _____ More than 3 years ago _____ Never has been to the dentist _____

2. Has your child gone to the dentist for routine care _____ **OR** emergency care _____? **(Please check one)**

3. Is your child experiencing oral pain (toothache, sore gums, etc.)? YES_____ NO _____

4. Is your child covered by Medicaid? YES _____ NO _____ **OR** **Nevada Check-Up?** YES _____ NO _____
Insurance # _____

5. Does your child have an established dentist? YES _____ NO _____ If yes, name of dentist_____

6. Do you have dental insurance, **other than** Medicaid or Nevada Check-Up, which covers your child? YES _____ NO _____

7. Has your child ever had a serious health problem?_____

8. Did you take your child to a hospital emergency room for a dental-related emergency this year? YES _____ NO _____

9. Is there anything we should know about your child prior to treatment?_____

10. Is your child on any medications, if **YES** list? _____

11. Does your child have any allergies (e.g., medicine, latex, nuts, etc.)?_____

----------**For Office Use Only**----------

Location EPOD: CL CU HO MA TA SA

Mobile: BA BAI BE CH DI FH GI KC MC PE RO TA WH WI WY **Other** _____ | **Northern NV.** _____