smallbites
PEDIATRIC DENTISTRY

Dental Sealant Program
PARENT AUTHORIZATION

Dear Parents,

A free dental screening and sealant program will be conducted in your child's school. This program, which helps prevent tooth decay, is for third and sixth graders. A dentist will screen your child's teeth and decide which teeth would benefit from sealants. Sealants would then be applied on your child's teeth to seal out food and bacteria that cause decay. In some instances, we may also provide Fluoride treatment to further protect your child's teeth. Please fill out this form and return to the school.

As a recipient of the Centers for Disease Control and Prevention's (CDC) State Actions to Improve Oral Health Outcomes (DP18-1810), this program adheres to all CDC infection prevention and control guidelines, including the Guidelines for Infection Control in Dental Health-Care Settings—2003, the Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care, and all relevant Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response.

PLEASE CHECK EITHER YES OR NO

☐ **YES**, I want my child to receive **SEALANTS** and/or **FLUORIDE** (Please fill in the entire form, sign below and return form)

☐ **NO,** I do not want my child to receive **SEALANTS** (Please fill in the entire form, sign below and return form)

☐ **NO**, I do not want my child to receive **FLUORIDE** (Please fill in the entire form, sign below and return form)

Child's Full Name: _____ Date of Birth: _____/_____/_____
Sex: _____M _____F

School: _____ Teacher: _____ Grade: _____

Child's Social Security #: _____ Parent Phone #: _____

Race/Ethnicity:

☐ American Indian/Alaskan Native
☐ Asian
☐ African- American
☐ Caucasian
☐ Hispanic
☐ Native American/Pacific Islander
☐ Other: _____

HEALTH HISTORY

Has your child ever had any seroius health problems? ___ Yes ___ No
If yes, please explain : _____

Does your child have any of the following allergies?

Acrylics/Plastics: ___ Yes ___ No

Other: ___ Yes ___ No

If yes, please list : _____

No payment is required from you for this program. However, the value of this service is more than $150 per child and we rely on insurances such as Medicaid, Delta Dental Smiles, or MCNA to help cover the costs. If your child is covered by dental insurance, please check the name of his/her insurance plan and fill in the ID numbers.

☐ BlueCross BlueShield
☐ Delta Dental Smiles
☐ MCNA
☐ Delta Dental of Arkansas
☐ Cigna
☐ MetLife:
☐ Other: _____

Insurance ID# (or) SS# of Employee: _____ Medicaid #: _____
Policy Holder Name: _____ Policy Holder Date of Birth #: _____

Signature of parent/guardian: _____ Relationship:_____

Date: _____

Did you receive the **Notice of Privacy Practices**? ____ Yes ___ No