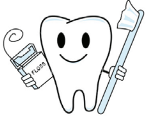
Providing comprehensive health care for everyone.

School Dental Program



What dental services are provided?

- ★ Oral Health Education
- ★ Cleaning
- ★ Exam
- ★ Crowns
- ★ Simple Extractions*
- ★ X-Rays
- ★ Fluoride
- ★ Sealants
- ★ Fillings
- ★ Root Canals*

**services for baby teeth only*

Who can I contact if I have questions?

Contact our School Program Coordinator:

Manitowoc: 920-973-9709
Email: mtwcschoolsdental@lakeshorechc.org

Sheboygan: 920-946-5689
Email: shebschoolsdental@lakeshorechc.org

Lakeshore Community Health Care, offers dental care for children currently enrolled in Manitowoc County & Sheboygan County schools.

If you would like to take advantage of this opportunity, please complete a consent form and return it to your child's school office.

Our professional staff will be available at your child's school to provide services during their day. Dental visits are scheduled throughout the school year. A representative will contact you prior to our scheduled visit at your school.

How will I be billed?

A claim for the services provided will be sent to your insurance company. Uninsured patients who qualify for a sliding scale fee will be asked to pay a co-payment.

Who qualifies for these services?
Any child who is NOT currently established with another dentist.
All children are accepted, regardless of insurance or ability to pay.

Accepting new patients with private insurance, Medicaid/BadgerCare, Medicare or who are uninsured.

SERVICES AT LAKESHORE

Medical & Behavioral Health

General Primary and Preventive Care
Chronic Disease Management
Chiropractic Services
Lab and X-Ray Referrals
Health Screenings
Counseling

Dental Services

Routine Exams and Cleanings
Fluoride Treatments
Fillings and Root Canals
Sealants
Dentures
Emergency Care

Support Services

Educational Programs
Insurance Enrollment
Case Management
Referrals to Community Agencies

Intérpretes Disponibles - Muaj neeg txhais lus - Interpreters Available

SHEBOYGAN	MANITOWOC*
920-783-6633	920-686-2333
1721 Saemann Ave.	2719 Calumet Ave.
Sheboygan, WI 53081	Manitowoc, WI 54220

Monday - Friday 7:30 am - 5:00 pm, call for extended hours.

www.lakeshorechc.org

Office Only:
MRN#________________

School Dental Program

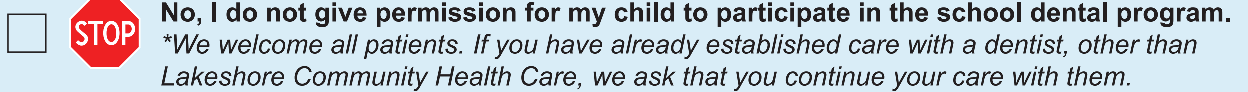
Please complete the consent form below. Thank you.

Child's First Name: ____________________ **Last Name:** ____________________ **Date:** __________

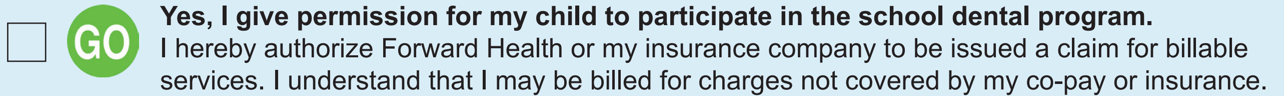
Section 1:

Is your child presently being seen by a dentist? ☐ Yes* ☐ No **If you currently have a dentist, please continue care with them.*

Is your child currently a patient at Lakeshore Community Health Care? ☐ Yes ☐ No



☐ STOP **No, I do not give permission for my child to participate in the school dental program.** **We welcome all patients. If you have already established care with a dentist, other than Lakeshore Community Health Care, we ask that you continue your care with them.*



☐ GO **Yes, I give permission for my child to participate in the school dental program.** I hereby authorize Forward Health or my insurance company to be issued a claim for billable services. I understand that I may be billed for charges not covered by my co-pay or insurance.

Print parent/guardian name:____________________ **Date of Birth:**__________ **Relationship to child:** ☐ Parent ☐ Step Parent ☐ Foster Parent ☐ Guardian ☐ POA

Does the child reside with you? ☐ Yes ☐ No *If you are not the parent of the child please provide documentation.*

If you would like to give permission for communication to additional persons, in regards to minor care or medication pick-up, list them here.

Name: ____________________ *Relationship to child:* ____________________ *Phone:* ____________________ ☐ *Check for Rx Pickup*

Address: ______________________________ *City, State and Zip:* ______________________________

If you have selected "GO" above, please provide complete information for Section 2 - Section 5.
Please fully complete these sections and sign on the back to prevent a delay in service.

Section 2:

Child's Date of Birth:__________ Grade:_______

School: ______________________________

Home Address: ______________________________

____
City, State and Zip

Preferred Communication *(List: 1,2,3)*: ___Call ___Text* ___Email

Phone to Call: ______________________________

Phone to Text: ______________________________

Email:______________________________

**Standard text messaging rates may apply.*

Section 3:

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ More than one race

Ethnicity: Hispanic/Latino ☐ Yes ☐ No

Speaks: ☐ English ☐ Spanish ☐ Hmong ☐ Other:____________________

Needs an Interpreter: ☐ Yes ☐ No

Homeless: ☐ Yes ☐ No

Section 4: What type of DENTAL insurance covers your child's dental services?

**No student will be refused services based on their insurance coverage.*

☐ **Forward Health/Medicaid/BadgerCare** Member ID #:______________________________

☐ **Private Insurance** (i.e. Delta Dental of WI, Anthem Dental, etc.)

Insurance Name: ____________________ *Member ID/Policy #:*____________________

*Policy Holder Name:*____________________ *Policy Holder Date of Birth:*____________________

Group #: ____________________ *Insurance Company Phone:*____________________

Claim Mailing Address: ______________________________

☐ **No Insurance:** *Uninsured patients will be asked to pay a flat co-payment based on household size and earnings.*

Total # of family members in household ______ **Total household earnings GROSS** (before taxes) ______________ ☐ Monthly ☐ Yearly

Section 5: Please complete the Student Medical History Form on the back side of this page.

It may be necessary for a LCHC representative to contact you prior to your child's exam.
Please respond back to us to ensure that your child will be seen while we are at their school.

School Dental Program

LAKESHORE community health care

Section 5: Please fully complete the following questions.

Name of Medical Physician: ______________________ Date of last exam: ____________
Medical Physician's phone: ______________________ Weight: ____________
Name of Medical Insurance: ______________________ Height: ____________

Yes ☐ No ☐ Does your child take any medications? If yes, please list them:

Yes ☐ No ☐ Does your child have any allergies? If yes, please explain:

Yes ☐ No ☐ Has your child ever had any serious illnesses or operations? If yes, please explain:

Yes ☐ No ☐ Has your child ever taken a pre-medication (antibiotic) before a dental visit? If yes, please explain:

Please explain: type of diseases, date of diagnosis, etc.

Yes ☐ No ☐ Down Syndrome: ____________
Yes ☐ No ☐ Cerebral Palsy: ____________
Yes ☐ No ☐ Autism: ____________
Yes ☐ No ☐ Mental Disability: ____________
Yes ☐ No ☐ ADD/ADHD: ____________
Yes ☐ No ☐ Muscular Dystrophy: ____________
Yes ☐ No ☐ Asthma: ____________ Inhaler in their possession at school? ☐ YES ☐ NO
Yes ☐ No ☐ Anemia/Sickle Cell: ____________
Yes ☐ No ☐ Heart Condition: ____________
Yes ☐ No ☐ Rheumatic Fever: ____________
Yes ☐ No ☐ Cancer: ____________
Yes ☐ No ☐ Thyroid: ____________
Yes ☐ No ☐ Liver Disease: ____________
Yes ☐ No ☐ Kidney Disease: ____________
Yes ☐ No ☐ Tuberculosis: ____________
Yes ☐ No ☐ Parasites: ____________
Yes ☐ No ☐ Epilepsy: ____________ Date of last seizure: ____________
Yes ☐ No ☐ Diabetes: ____________
Yes ☐ No ☐ Skin Disorder: ____________ Please list type/variety: ____________
Yes ☐ No ☐ Pregnancy: ____________ How many weeks: ____________
Yes ☐ No ☐ Hepatitis: ____________
Yes ☐ No ☐ Herpes: ____________
Yes ☐ No ☐ HIV/AIDS: ____________
Yes ☐ No ☐ STD: ____________

Any other medical concerns:

I agree to have LCHC contact my medical physician to release medical information pertaining to my child's dental needs. I agree to the sharing of information between my child's school and the LCHC dental program.

Parent or Guardian's Signature: ______________________ **Date:** ____________

This form is good for one year from signed date.