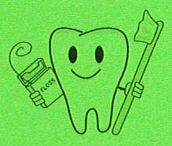
LAKESHORE
community health care

Providing comprehensive health care for everyone.

School Dental Program



What dental services are provided?

- ★ Oral Health Education
- ★ Cleaning
- ★ Exam/Oral Assessment
- ★ 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 (LCHC), offers dental care for children currently enrolled in Manitowoc County and 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. Each school sends out announcements of dates LCHC will be at your child's school.

How will I be billed?
A claim for the services provided will be sent to your insurance company. Private insurance may not cover all services. 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.

SERVICES AT LAKESHORE

Medical & Behavioral Health

General Primary and Preventive Care
Chronic Disease Management
Pharmacy
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

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

Office Only:
MRN#_____

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Please complete the consent form below. Thank you.

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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: Total # of family members in household: ____ Total household earnings GROSS (before taxes): _____

☐ Monthly ☐ Yearly

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.*

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.

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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. I understand that not all services may be covered by my private insurance.

Parent or Guardian's Signature: _____ **Date:** _____

THIS FORM IS GOOD FOR ONE YEAR FROM SIGNED DATE.

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Section 6: Authorization for Treatment

I do hereby acknowledge, agree and give my consent for dental diagnosis and treatment as deemed necessary by Lakeshore Community Health Care (LCHC) as indicated appropriate by my treating provider, their assistants and/or designees. This authorization includes, but is not limited to, routine procedures, x-rays, fluoride treatment, cleaning, sealants, fillings, Silver Diamine Fluoride, crowns*, root canals*, simple extractions* (*services for baby teeth only) and other tests or procedures. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or provider whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as result to examination and treatment received. I acknowledge that my care is under the direction of my treating provider and LCHC will follow the instructions of my provider(s) in the position in said care.

I understand that I am financially responsible to LCHC as the patient, guardian, and conservator or insured for all services not covered by insurance. Charges may include dental insurance deductibles, co-insurance and out-of-pocket expenses.

I acknowledge notification of LCHC's Privacy Practices and Patient Rights and Responsibilities. LCHC is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of LCHC, OCHIN supplies information technology, including

LAKESHORE Health Connect and related services to LCHC and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by LCHC with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

Patient/Legal Guardian Signature _____ **Date:** _____

Please complete the Treatment Consent form on the following page.

Silver Diamine Fluoride Treatment Consent

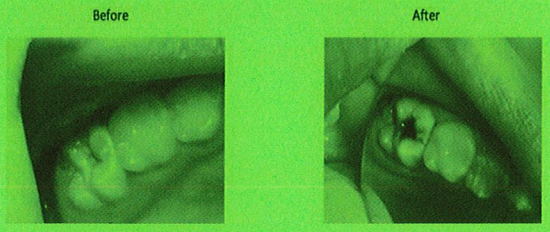
Silver Diamine Fluoride may be recommended to treat your child, especially younger children or children with high anxiety. Please review the following information. Reach out to our school dental program coordinator with any questions and sign and date at the bottom.

Patient Name: _____ **Date of Birth:** _____

Silver Diamine Fluoride (SDF) is a liquid medication that is applied to an active area of decay (cavity) to kill the bacteria causing the cavity, prevent the formation of a plaque layer on the treated surface, and strengthen the tooth.

It is very important that you are made aware that treating cavities with this medicine will cause color changes to the lesions (cavity). The areas of the tooth with active dental decay will turn dark black as the medicine is working. The healthy areas of the tooth will not be affected and will remain your child's natural tooth color. The black color indicates that the treatment is successful.

Examples of teeth treated by Silver Diamine Fluoride.



- If Silver Diamine Fluoride comes in contact with skin/gums, temporary discoloration will occur.
- Silver Diamine Fluoride may discolor teeth that have tooth-colored (resin) restorations, as well as demineralized (soft) enamel.
- Patients that have allergies to certain metals, including silver, should NOT receive SDF.
- A 5% Sodium Fluoride varnish will be used to seal Silver Diamine Fluoride onto the teeth, as well as prevent other cavities.
- Patient may need multiple treatments of Silver Diamine Fluoride. No guarantee of results can be made.

It is important that you are aware that this medicine will treat the bacteria causing tooth destruction, but will not restore (fill) the tooth structure that has already been affected by the disease process. **You may still require restoration of the teeth (fillings, crowns and possibly nerve treatment) if there is any loss of tooth structure.** The timing of additional treatment will vary, and we will discuss the best way to provide this treatment to ensure that you receive treatment in the least invasive, most predictable and least traumatic way possible.

I grant LCHC permission to provide my dental treatment as discussed. I also understand that this treatment may not be covered by my insurance (if applicable) and any estimates of insurance coverage discussed by any staff member were provided to me as a courtesy. It is my responsibility to contact my dental insurance company (including any insurance provided by the state) to discuss and understand my policy.

I agree to inform Lakeshore Community Health Care of any changes in my medical history. This authorization is valid until revoked by me in writing.

Patient/Legal Guardian Signature _____ **Date:** _____