Dental Sealant Program | Informed Consent and Medical History Form

Dear Parent or Guardian(s):

The County Health Department Dental Program is offering free dental screenings, cleanings, fluoride varnish and dental sealants at your child's school. **Please fill out this form and return it to your child's school to allow your child to participate.**

Dental screenings provide a quick and easy way to see if your child has any obvious dental issues that are in need of care. A dental screening does not replace a complete dental examination. Your child should visit the dentist for a complete examination every 6 months.

What are dental sealants? Dental sealants are thin, plastic coatings that are painted on the chewing surfaces of the permanent back (molar) teeth to prevent cavities.

What is fluoride varnish? Fluoride helps strengthen teeth and prevent cavities. *Fluoride varnish can be applied 2 - 4 times per year.*

Child's Name _____ Date of Birth (MM/DD/YY) _____ Child's Age_____

Address _____ City _____ Zip Code_____

Male ___ Female ___ Parent/Guardian Daytime Phone Number_____

School _____ Grade _____ Teacher _____

Race | Ethnicity:

☐ White
☐ Black|African American
☐ Asian
☐ Native Hawaiian|Pacific Islander
☐ Native American|Alaska Native
☐ Other

Is your child Hispanic or Latino?

Yes_____ No_____

Medical History - Please check if your child has or has had any of the following medical conditions:

___ Asthma
___ Diabetes
___ Tuberculosis (TB)
___ ADHD
___ AIDS/HIV
___ Epilepsy/Seizures
___ Bleeding Problems
___ Hepatitis
___ Emotional Disorder
___ Latex Glove Allergy

Does your child have any allergies? If yes, please list: _____

_____

List any medications your child is currently taking: _____

_____

Has your child seen a dentist in the past 12 months? Yes _____ No _____

No payment is required from you for this program. However, Medicaid may help cover the cost of this program. I understand that the Health Department will seek reimbursement for services if my child has dental coverage through Medicaid. Please fill in the insurance information below:

Dental insurance Status: _____Medicaid _____Private Dental Insurance _____Uninsured/Other/Unknown

I am the parent or legal guardian of the minor child named above. I acknowledge receipt of the Maryland Department of Health and Mental Hygiene's Notice of Privacy Practices effective September 2013 and hereby give my free and informed consent for the named child to receive:

Dental screening _____ Dental Cleaning _____ Sealants _____Fluoride varnish _____

X_____ _____ _____

Signature of Parent/Guardian | Print Parent/Guardian Name | Date

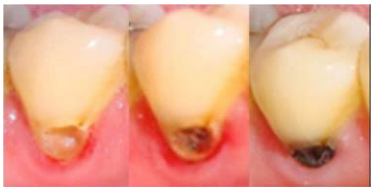
Montgomery County DHHS School-Based Preventative Dental Services Program
Informed Consent for Silver Diamine Fluoride

Patient Name:_____ Date of Birth:_____

Facts for consideration:

- Silver Diamine Fluoride (SDF) is a liquid that helps stop tooth decay. SDF maybe applied every 3, 6 or 12 months.
- A small amount of SDF may be applied to the decayed tooth area.
- After SDF application no eating or drinking for 30 minutes.

Pictures of stain from SDF



Benefits of receiving SDF:

- Helps stop decay.
- Fast.
- Do not need to numb, or drill teeth.
- Does not hurt.

Risks of receiving SDF:

- The affected area will stain black permanently. This means the SDF is working.
- Tooth-colored fillings and crowns may discolor if SDF is applied to them. Healthy tooth structures will not stain.
- If accidentally applied to skin or gums, a brown or white stain may appear that causes no harm, cannotbe washed off and will disappear in one to four weeks.
- Could permanently stain clothing dark.
- Might not stop the decay. Additional SDF may need to be applied on a different day.
- After SDF treatment, a filling or crown might still be needed.
- Not all decay can be treated with SDF.

Risk if not treated:

- If decay is NOT treated, it may get worse, and you may lose the tooth or may need more dental work to save the tooth. If not treated, you may experience tooth pain or a life-threatening condition.

I should not be treated with SDF if 1) I am allergic to silver 2) there are painful sores or raw areas on my gums or anywhere else in my mouth.

I HAVE READ AND UNDERSTAND THIS FORM. ALL OF MY QUESTIONS ABOUT TREATMENT, INCLUDING THE BENEFITS, SIDE EFFECTS, AND RISKS WERE ANSWERED.

I consent and authorize the dentist or dental hygienist from the Montgomery County Department of Health and Human Services Program Dental to use Silver Diamine Fluoride to help stop tooth decay.

Patient name: _____

Parent/Guardian name: _____

Signature:_____Date: _____

DHHS
MONTGOMERY COUNTY
Department of Health and Human Services

CLIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Department's *Notice of Privacy Practices*:

By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Client	Date of Birth	Signature of Client/Parent/Guardian	Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the department may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the DHHS will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Name	Relationship	Address, or DOB, or Telephone #

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the DHHS make all communications to me by the alternative means or locations that I have listed below.

Home Telephone Number:

☐ OK to leave message with detailed information
☐ Leave message with call back numbers only

Written Communication Address:

☐ OK to mail to address listed above
☐ E-mail me at:

Mobile/Cell Telephone Number:

☐ OK to Text message with detailed information
☐ Leave message with call back numbers only

Fax Communication:

☐ OK to Fax at the number listed above
☐ E-mail me at:

Work Telephone Number:

☐ OK to leave message with detailed information
☐ Leave message with call back numbers only

Other:

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Department.

2. These Authorizations may be revoked at any time by notifying the Department in writing at the Departments mailing address marked to the attention of "HIPAA Privacy Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____ _____

Name of Client (Printed) Signature of Client Date