AZ Kidz
HEALTHY SMILES

Dear Parent or Guardian:

Affiliated Practice Dental Hygienists will be at your child's school to conduct an oral health program. With your signed consent (attached form), your child will be seen by a caring hygienist to receive important and necessary preventive dental services. Your child may already be receiving these and other services at your own dental office. If so, we encourage you to continue with that care. However, if your child does not have a dentist or does not visit one on a regular basis, this is a wonderful opportunity to help prevent cavities.

PROCEDURES THAT WILL BE PROVIDED FOR YOUR CHILD:

- **Dental Screening:** A free checkup of your child's teeth to see if there are any obvious problems. No x-rays are taken, and this does not replace a regular exam by a dentist.
- **Cleaning:** To remove plaque and polish teeth.
- **Sealants:** This helps seal out food and bacteria from the grooves of the back teeth. Sealants help prevent cavities on the chewing surfaces of teeth.
- **Fluoride Varnish:** Fluoride varnish is brushed on the teeth with a small brush. It helps prevent cavities, by putting minerals into the tooth, making it stronger.
- **Silver Diamine Fluoride (SDF):** Silver Diamine Fluoride (a clear liquid) is painted on an existing, active cavity and STOPS THE DECAY PROCESS. SDF kills the bacteria causing decay and the destruction stops thus helping the patient to avoid a dental emergency down the road. SDF is endorsed by the Pediatric Dental Association as a safe and effective way of stopping cavities and has proven to be especially helpful on children who are terrified of the dentist and require full anesthesia for dental treatment. The only side effect is cosmetic. The decay will turn black (versus dark brown) once deactivated which is a sign that it was effective.
- **S.M.A.R.T. technique:** A technique to halt decay and seal teeth using two products: silver diamine fluoride (SDF) and glass ionomer sealants in a single appointment. It's a quick, painless alternative to 'drill and fill'. SDF is placed on the tooth to stop the decay followed by a GI sealant placed in the hole to seal out the nutrient source for any surviving bacteria. Method endorsed by the American Academy of Pediatric Dentistry.
- **Patient Education/Instruction:** Your child will be taught how to care for their teeth. A copy of your child's oral health screening results will be sent home, along with a copy to the school nurse. All necessary referrals will also be provided in the oral health report.

Your child can continue to see any dentist and receive treatment at any dental office. However, AHCCCS and any other dental insurance will be billed for services provided by our team when applicable. Please note that if you have dental insurance, this treatment may affect future rights and insurance benefits. Please bring your child's oral health report to your next dental office visit with your child's dentist so that they know what procedures were provided.

If you would like your child to participate, check **"YES"** on the attached permission medical history form. **Complete and sign the permission form** and return it to your child's teacher as soon as possible. AZ Kidz Healthy Smiles is confident your child will have a positive experience and better oral health. The screening and services provided do not take the place of a regular dental exam. We recommend a follow-up exam with a dentist within 90 days. It is very important your child see a dentist on a regular basis to stay healthy and avoid dental problems to be better prepared to learn. We will provide a list of dentists in your area for future needs if needed.

We look forward to bringing dental hygiene services to your child in their safe, comfortable school environment.

If you have any questions, please call **602-684-4965** or email **azkidzhealthysmiles@gmail.com**

AZ KIDZ HEALTHY SMILES FOUNDATION
School Dental Program Permission and Medical History Form

Child's Name: _____ Date of birth: _ _ /_ _ /_ _ _ _ ☐ Male ☐ Female
(First) (M.I.) (Last) (month / day / year)

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

Home Address: _____ City: _____ Zip: _____

Parent's Email: _____ ***PLEASE VISIT: azkidzhealthysmilesfoundation.org*** *for more information*

☐ **YES**, I give permission for my child to participate in the preventive school based dental program.
Please bill appropriate insurance company below for services provided. ***Please complete entire form and sign below.***
☐ **NO**, I do **NOT** give permission for my child to participate in the dental program. ***Please complete name and grade only.***

General Information:

1. What language does your child speak best? _____ What language is spoken at home? _____
2. What is your child's race?
   ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ White ☐ Other _____

Health Information:

3. Does your child see a doctor for regular checkups? ☐ YES ☐ NO **If yes**, please name _____
4. Does your child see a dentist for regular checkups? ☐ YES ☐ NO **If yes**, please name _____
5. In general, how would you describe the health of your child's teeth and mouth? Date of last dental visit:_____
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
6. Is your child taking any medication now? ☐ YES ☐ NO **If yes,** please list:_____
7. Has a dentist/doctor ever said your child needs antibiotics (penicillin) before dental treatment? ☐ YES ☐ NO
8. Please check any illnesses or conditions your child has EVER had:
   ☐ ADD/ADHD ☐ Diabetes ☐ Hepatitis ☐ Rheumatic Fever ☐ Convulsions ☐ Anemia ☐ Epilepsy ☐ Heart Murmur
   ☐ Seizures ☐ Allergies to Medicine ☐ Asthma ☐ Heart Conditions ☐ Kidney/Liver ☐ Tuberculosis ☐ HIV/AIDS
9. Does your child have any other health conditions? ☐ YES ☐ NO **If yes**, please list: _____
10. Does your child have any allergies? ☐ YES ☐ NO **If yes**, please check all that apply or explain: _____
    ☐ Antibiotics ☐ Penicillin ☐ Colophonium ☐ Aspirin ☐ Latex ☐ Resin/Rosin ☐ Food/Other:_____
11. Does your child have dental insurance? ☐ YES ☐ NO **If yes**, complete below.

AHCCCS Patient Information (AHCCCS only)
Child's Name on card: _____
AHCCCS Member ID #:
_____

Dental Insurance Company Information (not AHCCCS)
Company: _____
Address: _____
Subscriber: _____
Subscriber ID #: _____
Subscriber Date-of-Birth (month/day/year) _____
Group/Policy #: _____
Employer Name: _____

I understand that AZ Kidz Healthy Smiles Foundation may use this health information for treatment, payment, and health care operations. I have received Right to Privacy and Program information. I have read and understand the dental program and services that may be provided to my child and consent that my child participates in this program. I understand that these services do not substitute for an examination by a dentist. I understand that my child should obtain an examination by a dentist within 90 days. I understand that my child may continue to obtain dental care through any other provider. I authorize the dental program to provide a written summary of services provided to a designated school official and to forward any referrals to my child's dentist of record when applicable. I understand that the program will provide a list of dentists in my area and will provide assistance in finding a dentist if needed.

If I have dental insurance, I authorize my insurance carrier to be billed for services provided. I understand that this treatment may affect future rights and insurance benefits.

Sign: _____ Date: _____ Relation to Child: _____
Parent/guardian signature (month/day/year)

Print name: _____ Mobile #: _____ Daytime Telephone #: _____

Name Emergency Contact *if parent can not be reached*: _____ Phone # _____