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**Gateway Oral Health Program**

**Increasing Access to Dental Care for Children in Northeastern Kentucky**

**This is a no-out-of-pocket preventative dental program provided by the Gateway District Health Department (GDHD), the Gateway Oral Health Program, and the Public Health Registered Dental Hygienist, under the direction of GDHD Board Dentist, State Dental Director, and the Department of Public Health Dental Hygiene Program.**

 The **BEST** way to protect children from tooth decay is to **STOP** it before it starts. Regular **Dental Assessments**, **Prophy** (cleanings), **Sealants,** and **Fluoride** are your child’s best friends when it comes to building strong, healthy, beautiful teeth for a lifetime.

**Fluoride**: Every child can benefit from fluoride. Under the gums is a regular little tooth factory that is busy making teeth, baby teeth and the adult (permanent) teeth. Even though you won’t see some of them for years, Fluoride starts making those teeth strong long before they come through the gums. Fluoride Varnish is a layer of fluoride that is painted onto the teeth*.* **Even if your child has received fluoride at the dentist they may have it again.** Fluoride varnish **can be applied up to six times a year**. Twice from your dentist, twice from a pediatrician or doctor, and twice from your public health hygiene program. It is easy, fast, and painless! Fluoride can prevent, slow down, and reverse the tooth decay process.

**Dental Sealants:** are protective coatings painted in the grooves of the back teeth (molars) that help in the prevention of cavities in the chewing surfaces of your child’s teeth. They can last up to 10 years with proper care and maintenance. In the long run can save lots of time and money in preventing extensive dental work. In fact, sealants are one of the most effective ways to prevent cavities and maintain good oral health.

Depending on your county and the services we provide:

Rowan- Full Hygiene Preventative Services

Bath, Elliott, Morgan, Menifee- Assessment and Fluoride Program, along with resources and referrals.

Our GDHD **Public Health Registered Dental Hygienist:** will visually screen your child’s teeth, may provide an age-appropriate dental cleaning (oral health education/nutrition /tobacco education included), dental sealants as needed, and apply Fluoride Varnish. A licensed dentist will not be present during the screening, nor required for the PHRDH to give this service (see KY Dental Practice act KRS 313.040). We are supported by the Dept of Public Health, KY Dental Director, Our Health Board, and several members of the local dental and healthcare community. Each child will receive a toothbrush, toothpaste, and a dental report card. If tooth problems are noted, a referral to a dentist will be made along with support and resources from our program.

***Only a licensed dentist may make a diagnosis of decay, PHRDH will refer for decay and support the patient/parent, and established dentist as needed****.*

**Please complete the back of this form to allow your child to participate.**

If you have any questions, you may contact:

Brooke Jones PHRDH, BSDH- Director of School Oral Health

by email @ brookel.jones@ky.gov or phone/text (606)548-3763

or contact us at Gateway District Health Department Rowan office at (606) 784-8954 ext. 3140

GDHD (12-2023)

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Office (606) 784 – 8954 ext. 3140 | Email- brookel.jones@ky.gov

Brooke Jones PHRDH, BSDH | Dir. Of School Oral Health

**Gateway Oral Health Program**

**CONSENT FOR**

**DENTAL TREATMENT**

**MEDICAL INFORMATION**

Has your child ever had any of the following (if yes, please explain below):

|  |  |  |
| --- | --- | --- |
| * Surgery | * Diabetes | * Hearing Loss/Speech Issues |
| * Bleeding Problems | * Heart Murmur | * Heart Problems |
| * Seizures/Epilepsy | * Autism | * ADD/ADHD |
| * Cancer/Chemo | * Asthma | * Antibiotic premedication |
| * Trauma (head, neck, mouth) | * Anxiety/Fear | * OTHER: |

**If yes, explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Daily Medication**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle all that apply: No Insurance Private Dental Insurance Medicaid**

**Medicaid Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MCO Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CIRCLE MCO: UNKNOWN AETNA ANTHEM HUMANA CARESOURCE PASSPORT WELLCARE MOLINA UNITED HEALTHCARE**

\*\*\*This service is provided to your child whether you have insurance, so do not worry. Medicaid Medical Provisions will be billed, but those without insurance or with private dental insurance are not billed. This should not affect your dental benefits!

**CONSENT FOR DENTAL SERVICES and ASSIGNMENT OF BENEFITS:** I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care for my child which may include dental screening/assessments, preventative dental treatment, and any other health service provided by staff or agents of this health department. I understand that no guarantees are being made as to the effect of any preventive service provided for my child. I also understand that no x-rays will be taken and that my child may be screened to check the retention of these sealants by the public health dental hygienist the following school year. I also understand that my child may be tested for HIV, Hepatitis B, or any other bloodborne disease should a health care worker be exposed to blood or bodily fluids. I authorize this health department to release dental information about my child, as permitted by HIPPA to his/her primary care physician, dentist, and school staff. I authorize the release of my child's dental records to a dentist for follow-up care and establishing a dental home. This program does not take the place of regular check-ups at a dental office. The services are being provided by a Public Health Registered Dental Hygienist. I understand that no dentist is present or required for the PHRDH to perform the dental procedures according to the KRS 313.040 KY Dental Practice Act. **PRIVACY**: This form, when completed and signed, contains Protected Health Information which will be protected according to the Health Insurance Portability and Accountability Act (HIPAA). My signature below acknowledges my understanding of Gateway District Health Department (GDHD) “*NOTICE OF PRIVACY PRACTICES” \*\*\* and how to receive a copy* on the date stated. I have read the above and I understand the items included in this packet as they apply to me and my child. Text messaging may be utilized. Text may contain personal health information regarding you and are not considered a confidential means of communication. Signature below indicates I do consent, authorize, and declare as stated above. Permission can be revoked at any time.

**ASSIGNMENT OF BENEFITS**: I request that payment of authorized insurance benefits be made to GDHD on my child’s behalf, for services received. I also authorize GDHD to release oral health information about my child to Medicaid to determine Payment for services.

**X*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Date*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Parent/Legal Guardian Signature**  (Expires at end of school year)

GDHD (12-2023)

***PLEASE PROVIDE ALL INFORMATION REQUESTED ON FORM***

***\*\*\* You can request a physical copy of our HIPPA form, view online by visiting GDHD.org, or request an emailed copy.***

“Sparkling Futures Start with A Sparkling Smile”

**DENTAL HISTORY**

**Dentist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Seen dentist every 6 months**: Y N

**Do you have trouble finding a dentist or need help locating a dental home**? Y N **Transportation issues getting to appointment offices**? Y N

***Please Print all Information Requested on Form and Return with Registration Forms***

**Child’s Name**: **Last**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MI**\_\_\_\_ **First**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Circle**: Male/Female  **Date of Birth:** \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Child’s Social Security Number (required)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Race**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hispanic/Latino**: Y N

**Phone #:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Utilized for connection of resources**: **#in Household**: \_\_\_\_\_\_ **Annual Income**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Legal Guardian**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to child**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Teacher**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Grade**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alternate Contact & phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_