OPTIONAL Ellsworth High School – 2026-2027

IF YOU **DO NOT** WANT YOUR CHILD TO PARTICIPATE OR THEY ALREADY HAVE A DENTIST – **DO NOT FILL OUT THIS FORM**. A Dental Hygienist will see your child during school hours (twice per year) to provide: oral screening, dental cleaning, fluoride varnish, oral hygiene instructions, sealants, temporary fillings and/or Silver Fluoride (SF). SF is used to temporarily manage cavities until your child is able to see a dentist for permanent fillings. When cavities are treated with SF, the tooth will turn dark, which is a good indication that the infection in the tooth is dying. If you DO NOT want SF used, please check this box. ☐

IF YOU WANT YOUR CHILD TO BE SEEN – THE ENTIRE FORM MUST BE COMPLETED OR IT WILL BE RETURNED TO YOU TO COMPLETE. THIS PROGRAM DOES NOT REPLACE AN EXAM BY A DENTIST.

PLEASE PRINT CLEARLY:
FULL NAME OF STUDENT: _____DOB: _____/_____/_____
GENDER: _____ SCHOOL: _____ GRADE: _____

PARENT/GUARDIAN INFORMATION:
PARENT/GUARDIAN NAME: _____
ADDRESS: _____
PHONE #: _____ EMERGENCY #: _____

PLEASE PROVIDE THE REQUESTED INFORMATION BELOW, AS IT MAY BE NEEDED INCASE OF EMERGENCY. IF THERE ARE NONE – PLEASE PUT N/A

MEDICAL CONDITIONS: _____
CURRENT MEDICATIONS: _____
ALLERGIES: _____

Do you have any dental questions/concerns? _____
Has your child seen a dentist or hygienist? ☐ YES ☐ NO Date of last visit: _____
Dentist Name or location of last visit: _____

IF YOU WOULD LIKE TO BE SELFPAY – Please BRING CASH OR CREDIT CARD that will be processed day of services

☐ 13 or older - $130 (cleaning & fluoride varnish) ☐ Sealants - $35 per tooth (recommend on molar teeth)

WE WILL ACCEPT THE FOLLOWING DENTAL INSURANCE: MAINECARE, DELTA DENTAL, METLIFE, CIGNA AND PATIENTS ADVOCATES.**PLEASE FILL OUT THE INSURNACE SECTION ENTIRELY.**

DENTAL INSURNACE: PLEASE PRINT CLEARLY Employer Name:_____
Company Name: _____ Policy/ID#: _____Group #: _____
Subscriber's Name: _____ Subscriber's date of birth: _____/_____/_____
Subscribers Address: _____
Insurance Company's provider line phone number: _____

I hereby give permission for my child to be seen throughout the school year. I understand that Sweet Smiles Dental Services is HIPPA compliant and all records are kept confidential and that claims to MaineCare insurance will be electronically transferred. By signing below, you are giving Sweet Smiles Dental Services authorization to share medical/dental information with other healthcare professionals.

PARENT/GUARDIANSIGNATURE: _____ **DATE:** ____/_____/_____