LA CLINICA
HAPPY SMILES

541-414-1575 http://laclinicahealth.org/happysmiles

****PLEASE RETURN COMPLETED FORMS TO YOUR CHILD'S SCHOOL AS SOON AS POSSIBLE****

All students at this school are eligible to take part in this dental care program. If you have insurance, we will bill it for eligible services. Otherwise your costs are covered primarily by generous funding from the Reed and Carolee Walker Fund of the Oregon Community Foundation.

Student name_____ **Birthdate**_____ **Sex - M/F**_____ **Race**_____

School_____ **Grade**_____ **Teacher**_____

Home address_____**City**_____ **ZIP**_____

Home phone_____ **Work or message phone** _____ **Is your child disabled?** Y / N

Does you child qualify for free or reduced-price lunch? Y / N **Family size**_____ **Annual income**_____

This program receives financial support from the community. To continue receiving this funding we must ask the following *(your answers will remain confidential)*:

Have you or anyone in your household worked in any of the following industries during the last two years? Please check all that apply:
□ Orchards □ Packing house □ Reforestation/tree planting □ Vineyards □ Crops/harvesting □ Fertilizing/turning of soil

In the past 24 months have you or someone in your household lived in one of the following situations: on the street or in a shelter, abandoned building or vehicle, transitional housing, recovery center, group home, or in any other temporary situation? Y / N

In the past 24 months have you and your family been forced to stay with friends or extended family or have you moved to temporary housing because of housing costs? Y / N

Does your child have a dentist? Y / N If yes, dentist name_____Dentist phone_____

When was the last time your child saw a dentist? (please circle one) 0-6 months 7-12 months over 12 months never seen

What type of dental Insurance does your child have? OHP Private None

Name of insured/subscriber_____ Birth date of insured_____

Name of employer_____ Dental insurance company_____

Insurance ID #_____ Insurance group #_____

Insurance company address _____Phone_____

I give permission for my child to receive the following services:

Yes___ No___ Fluoride varnish (two per year) with a visual dental screening. The American Academy of Pediatrics considers fluoride varnish to be safe and effective in the prevention of cavities in school-age children.

Yes___ No___ Dental sealants along with a brief visual screening. According to the American Dental Association, sealants (plastic coating applied to the chewing surfaces of teeth) are recognized as an effective approach to preventing cavities in children.

If my child is insured, I understand that La Clinica will bill my insurance for eligible visits. I have provided complete and accurate information.

Parent/guardian signature_____ **Date**_____

I have received a copy of the Notice of Privacy Practices _____ **Date**_____

Please sign here and keep the attached copy for your records

The dental health screening provided through this program is a brief visual exam and does not take the place of a complete dental exam done by a dentist. This visual screening is not a diagnosis or a treatment plan. If you have concerns or your child is experiencing dental pain you need to make an appointment with a dentist for a complete examination. La Clinica provides these services through support from the Walker Fund and through contributions by Oral Health America.

Voltear para Español →