


Dear Parent/Guardian,

Your school needs your help!
COMTREA Dental and your child's school are working together to offer a dental program for all students. If your child has Medicaid or commercial insurance, COMTREA will bill the insurance for reimbursement. Fees for children with no insurance will be waived for one visit per school year.

WHO: Anyone!

WHAT: A dental team will come to the school to offer dental services for your child. This program also allows your child to help their school determine the dental health and needs of the whole community.
Check the first box on the attached form if you would like the **screening**:

- A screening by a registered dental hygienist (this is always free of charge!)
- Fluoride painted on their teeth to help fight cavities
- Sealants applied to their adult molars to help fight cavities, replacement of sealants if needed
- Dental education and a dental goody bag

If you check the box for the **exam**, the program includes **the above PLUS**:

- Comprehensive exam by a dentist and x-rays
- Teeth cleaning
- Please be sure to include all insurance information.

WHY: To help your school district determine its dental health needs

WHERE: Your child's school!

WHEN: During the school day of this school year, your nurse will be given the exact date. Please fill the form attached and return to the school nurse or front office by **SEPTEMBER 6.**

MORE INFO: Your child will be sent home with a summary letting you know what we recommend, which will also be shared with your school nurse. Our dental Patient Care Coordinator will contact you to discuss treatment needs.

Thank you for helping your school collect key information that will help all students!

COMTREA
HEALTH CENTER

TOOTH TITANS CONSENT FORM

AS A FEDERALLY QUALIFIED HEALTH CENTER, WE ARE REQUIRED BY THE BUREAU OF PRIMARY HEALTH CARE TO COLLECT DATA ON ALL PATIENTS. COMTREA DOES NOT DISCRIMINATE BASED ON AGE, SEX, RACE, CREED, MARITAL STATUS, RELIGION, NATIONAL ORIGIN, DISABILITY, SEXUAL PREFERENCE, PUBLIC ASSISTANCE STATUS OR CRIMINAL RECORD.

PLEASE PRINT NEATLY AND RETURN TO THE SCHOOL NURSE

❑ **YES!** I GIVE PERMISSION FOR: SCREENING, FLUORIDE, SEALANTS/SEALANTS REPAIR. INSURANCE INFORMATION REQUIRED FOR SERVICES.
❑ **YES!** I GIVE PERMISSION FOR ALL OF THE ABOVE **PLUS**: EXAM, X-RAYS, CLEANING AND PHOTOS FOR THEIR DENTAL CHART- INSURANCE INFORMATION REQUIRED FOR SERVICES.
❑ **NO**. I DO NOT WANT MY CHILD TO PARTICIPATE. WHY? (OPTIONAL) _____

HAS YOUR CHILD EVER BEEN SEEN BY A DENTIST? ◯ YES, WITHIN ONE YEAR ◯ YES, OVER ONE YEAR AGO ◯ NEVER

GENERAL INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTH DATE	❑ MALE ❑ FEMALE
SOCIAL SECURITY NUMBER	GRADE LEVEL	SCHOOL NAME		TEACHER
PARENT/GUARDIAN NAME	PHONE	CELL/ALTERNATIVE PHONE	EMAIL	
MAILING ADDRESS		CITY		ZIP CODE
PHYSICAL ADDRESS (IF DIFFERENT)		CITY	ZIP CODE	COUNTY OF RESIDENCE
PREFERRED METHOD OF COMMUNICATION (CHECK ALL THAT APPLY) ❑ PHONE/CELL ❑ EMAIL ❑ TEXT ❑ PATIENT PORTAL ❑ LETTER				
SECONDARY CONTACT NAME (PERSON NOT LIVING WITH YOU)		RELATIONSHIP		PHONE
CHILD'S PRIMARY PHYSICIAN		PHONE		

ADDITIONAL INFORMATION

ETHNICITY: ❑ HISPANIC/LATINO ❑ NOT HISPANIC/LATINO ❑ DECLINE	RACE: ❑ WHITE ❑ BLACK/AFRICAN AMERICAN ❑ AMERICAN INDIAN OR ALASKA NATIVE ❑ ASIAN ❑ NATIVE HAWAIIAN ❑ OTHER PACIFIC ISLANDER ❑ MORE THAN ONE RACE ❑ DECLINE	HOUSING: ❑ NOT HOMELESS ❑ HOMELESS (WITHOUT PERMANENT HOUSING)
PREFERRED LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ OTHER: _____	LANGUAGE ASSISTANCE: IF YOUR CHILD NEEDS SUCH ASSISTANCE, WHAT KIND IS REQUIRED? ❑ SIGN LANGUAGE ❑ VISUAL AIDES	

THE FOLLOWING QUESTIONS ARE ABOUT EVERYONE LIVING AT HOME WITH YOUR CHILD

NUMBER OF ADULTS LIVING AT HOME _____ NUMBER OF CHILDREN LIVING AT HOME _____

TOTAL ANNUAL HOUSEHOLD INCOME _____ (ESTIMATE GROSS INCOME FROM WAGES, CHILD SUPPORT, ALIMONY, DISABILITY, SSI, UNEMPLOYMENT)

INSURANCE

DENTAL INSURANCE: ❑ UHC (THROUGH MEDICAID) ❑ MISSOURICARE ❑ HOMESTATE ❑ MOHEALTHNET ❑ NO INSURANCE ❑ PRIVATE: _____ UNINSURED? ASK ABOUT OUR SLIDING FEE SCALE

ID NUMBER	GROUP NUMBER	PRIMARY MEDICAL INSURANCE

ACCOUNT TO BE PAID BY: (SUBSCRIBER'S INFORMATION)

NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	❑ MALE ❑ FEMALE
RELATIONSHIP TO PATIENT	PHONE	EMAIL	
ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP CODE

DOES YOUR CHILD HAVE ANY ALLERGIES? YES ◯ NO ◯ IF YES, PLEASE LIST

IS YOUR CHILD TAKING ANY MEDICATIONS? YES ◯ NO ◯ IF YES, PLEASE LIST

PLEASE LIST ANY MEDICAL HISTORY HEALTH ISSUES:

CONSENT FOR DENTAL DIAGNOSTIC AND PREVENTIVE TREATMENT & ASSIGNMENT OF BENEFITS

I/We hereby give my/our permission for my/our child to participate in COMTREA's Tooth Titans mobile program. I consent for COMTREA to provide dental preventive services (including but not limited to screenings, fluoride, exam, x-rays, and sealants). I acknowledge that a dentist may not be present and that a teledentistry exam may be used to provide an exam using electronic review of my child's records by a COMTREA dentist. I acknowledge that I am able to exercise my rights under HIPAA of 1996 to access COMTREA's privacy policy by visiting their website at ***www.comtrea.org*** *and that all information shared here is confidential. I understand that my child's oral health results will be shared with the school nurse for the purposes of data collection and care coordination. I understand this consent is valid for 1 year from the date of signature. I/We understand that eligible services may be billed to Medicaid and/or private insurance. A Sliding Fee Discount Program will be provided to eligible persons based on the patient's ability to pay. I hereby instruct and direct all proceeds of insurance to be paid to COMTREA Inc. for the dental and/or medical expense benefits allowable, and otherwise payable to me, under my current insurance policy as payment toward the total charges for the professional services rendered. I authorize COMTREA Inc. to release or receive information on eligibility and/or benefit information for the purpose of filing insurance claims. I also understand that additional information may be needed from my file to achieve maximum benefits. My signature will be kept on file for the filing of future insurance claims. I understand this consent may be revoked at any time upon my request. Further, I/We as the applicant's parent (s) or guardian (s) authorize COMTREA or individuals designated by COMTREA to act for me/us in an emergency, accident or illness.*

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

PRINTED NAME _____ ❑ **I CONFIRM THAT EVERY APPLICABLE FIELD IS COMPLETED**

COMTREA HEALTH CENTER