Forsyth’s Oral Health Program helps keep children and teens healthy by bringing dental prevention right to where they live and learn. Keeping your child’s mouth healthy is our goal.

Children who see a dentist regularly SHOULD NOT enroll in Forsyth’s Oral Health Program. Please continue to take your children to their regular dentist.

The program offers the following services:

- **Dental Exam**: up to three times a year
- **Teeth Cleaning**: up to two times a year
- **Fluoride Treatments**: up to four times a year to prevent cavities
- **Dental Sealants**: as needed to prevent cavities on chewing surfaces of teeth
- **Oral Health Education**: at each visit to teach children how to care for their teeth at home
- **Nutritional Counseling**: at each visit to explain how eating healthy prevents cavities
- **Toothbrush and Toothpaste**: up to two times a year
- **Sedative Fillings**: as needed to stop decay until a child can visit the dental office
- **Dental X-rays**: as needed to identify cavities and other dental problems
- **Take-Home Form**: at each visit with information about your child’s needs and care provided
- **Follow-Up Assistance**: as needed if follow-up care is required, or if your family does not have a local dentist.

Forsyth services do not replace a visit to the dental office.

**Participation:**
- Any child may participate
- Enrollment is voluntary
- If your family does not have dental insurance, you may enroll your child in the program at no cost
- If your child is covered by MassHealth or private dental insurance, Forsyth will bill for services provided but there is NO co-pay, fee or charge to your family
- You may withdraw your child from the program at any time by sending an email to forsythkids@forsyth.org.

**Program Staff**: Forsyth is staffed by Massachusetts licensed dentists, dental hygienists and dental assistants. Patient Advocates will help you find a dentist in your community if your child needs follow-up dental care.

**Notice of Privacy Practices: Please see the enclosed information.** Forsyth follows federal and state guidelines for protecting patient information. As part of the program, your child’s dental information will be shared with the school nurse and/or other designated official(s). You will receive a written report of the dental services provided following each Forsyth visit. You may request a copy of your child’s dental records at any time in writing via email at forsythkids@forsyth.org. We may contact you directly about your child’s dental health.

Consents are available in the following languages: Portuguese, Vietnamese, Haitian Creole, Arabic. Please contact Forsyth or the school nurse for help in these and other languages.

**Questions**: If you have questions, please contact

**Email**: forsythkids@forsyth.org
**Phone**: 617-892-8323
ForsythKids and ForsythTeens Oral Health Program Consent Form

Last Name: ______________________________
First Name: ______________________________

☐ Male ☐ Female Date of birth: _____ / _____ / ______ Child’s Primary Language: __________________

School/Site: ____________________________ Grade: ________ Room #: ______________ Teacher: __________________________

Parent/Guardian’s Name: ___________________________________________ Parent/Guardian’s Primary Language: ___________

Parent/Guardian’s Address: _________________________________________ Apt.: _______ City: __________ State: _____ Zip: _______

Parent/Guardian’s Phone #: Home _______ Cell: ___________________

I give permission to call my cell phone ☐ Yes ☐ No

Dental Information

- Date of last dental check-up: Month _____ Year ______
- My child has a local dentist. ☐ NO ☐ YES Dentist Name: ________________________________
- Does your child see the dentist on a regular basis? ☐ NO ☐ YES
- Does your child need to take antibiotics before having dental treatment? ☐ NO ☐ YES Why? _________________________
- Please tell us about your child’s dental experiences: __________________________________________________________
- Have you (Parent/Guardian) ever had a toothache? ☐ NO ☐ YES

Medical Information

- Name of Medical Doctor or Primary Care Provider: ____________________________ Phone#: ______________________
- Do you have a serious medical condition? ☐ No ☐ Yes
  If Yes, please (✓) which one(s) below
  ☐ Heart Murmur/Heart Disease ☐ Asthma ☐ Seizures/Epilepsy
  ☐ Kidney/Liver Disease ☐ Immunologic Disorders ☐ Blood Disorders ☐ Tuberculosis ☐ Diabetes
  ☐ Cancer ☐ Disabilities/Special Needs ☐ ADD/ADHD ☐ Autism ☐ Hepatitis A/B/C ☐ HIV Disease
- Current medication(s) ☐ No ☐ YES Name of medication(s): ________________________________
- Allergic to: ☐ None ☐ Penicillin ☐ Antibiotics ☐ Latex ☐ Foods ☐ Nuts/Tree nuts ☐ Dyes Other: ________________________

Other Information

Race: ☐ Black/African American ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Hawaiian/Pacific Islander
  ☐ More than one race ☐ I do not wish to answer

Hispanic Origin: ☐ NO ☐ YES ☐ I do not wish to answer

Housing: ☐ Own ☐ Rent ☐ Transitional (e.g.: YMCA, Hotel, Shelter) ☐ I do not wish to answer

I give permission for photos or videos to be taken during a Forsyth clinic visit: ☐ NO ☐ YES

Insurance Information

☐ MassHealth

MassHealth number: __________________________ Individual Policy #: __________________________

☐ Other Dental Insurance Name: __________________________ Group Policy #: __________________________

Address of Insurance Company: ______________________________________________________________

Subscriber Name: __________________________ Subscriber ID: __________________________

Employer Name: __________________________

Subscriber Date of Birth: _____ / _____ / ______

I agree that the above information is correct and have read the program description on the opposite page. I authorize Forsyth to release my information, including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care, to third party payors and/or health practitioners. I understand that my child can receive care using this signed consent form for the duration of my child’s enrollment at the school/site. I understand that Forsyth bills my dental insurance for the dental services provided. I received the ForsythKids Notices of Privacy Practices. I understand I may withdraw my child from the program at any time via email to forsythkids@forsythkids.org.

Signature Parent/Guardian: __________________________ DATE: _____ / _____ / ______

September 2013
Revised 5/11/2016