Tillamook County Community Health Centers

Fluoride Varnish for Healthy Teeth

Please return a signed permission slip to use this service.

Fluoride varnish and dental screenings are offered at your child's school for no cost to you (insurance will be billed). A dental screening is a quick look inside your child's mouth to check the overall health of their teeth. Fluoride varnish is a protective coating brushed on the teeth.

For more information, please call us at 503-842-2356.

What you need to know:

- Fluoride varnish is a safe and quick way to protect teeth from cavities
- Fluoride varnish does not hurt
- Screenings and fluoride varnish are done by dental care professionals

Keeping A Healthy Smile

- Brush and floss every day
- Use fluoride toothpaste the size of a grain of rice
- Choose healthy snacks such as fruits and vegetables
- Try drinking water over juice
- Healthy baby teeth will help prevent problems in adult teeth
- See a dentist at least once a year

Revised July 2021

Dental Screening/Fluoride Varnish Program Permission Slip

No cost to you (insurance billed) dental screenings and fluoride varnish services are now offered at your child's school. Fluoride varnish is a quick and easy way to protect teeth from cavities. The screening and fluoride varnish are done by dental care professionals up to four times a year.

Name of Child: _____
(Last) (First) (Preferred Name)

Child's Date of Birth (mm/dd/yy):_____ /_____ /_____ Gender: ☐Male ☐Female

Dental Screening: a quick look inside the mouth to check the overall health of teeth

☐YES ☐ NO

Fluoride Varnish: applied to teeth to prevent cavities

☐YES ☐ NO

If Yes, Please Complete and Sign Below:

Contact Information	
Parent/Guardian:	
Best phone number to reach you:	Permission to Text: ☐ Yes ☐No
Email address:	
Mailing address:	

Please provide the following information so we can better serve your child:

My child is taking (list medications):	None: ☐
My child is allergic to:	None: ☐
Any current medical problems:	None: ☐
Other information to help us better serve your child:	None: ☐

Please complete the section below.

Health Insurance: ☐ Oregon Health Plan (OHP) / Medicaid ID# _____ ☐ Private dental insurance company _____ ☐ No health insurance	These services are at **no cost to you!*** *insurance will be billed

By signing below you:

As the legal parent/guardian, I hereby consent to the release and exchange of information, including any relevant personal health information regarding the services provided, between the dental staff, Head Start staff, your child's future school district or ESD, insurance carriers, the child's dentist, applicable Coordinated Care Organization, and/or the Dental Care Organization of record. I have received a copy of "Notices of Privacy Practices." Privacy Practices are available on the Tillamook County Community Health Center website https://tillamookchc.org/patient-forms/.

Parent/Guardian Signature:_____ Date: _____

Tillamook County Community Health Centers

Collecting demographics helps us better serve our community.

Name: _____ Date: _____
(Last) (First)

Ethnicity (optional)

- ☐ Hispanic
- ☐ Non-Hispanic

Race (optional) Please check all that apply

- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White
- ☐ Other

Language (optional)

- ☐ _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The confidentiality of your protected health information, also called your medical record, is a high priority at Tillamook County Community Health Center. There are a number of reasons we may need to use this information or disclose it to others. This Notice of Privacy Practices is provided to inform you of the ways we can use and release information from your medical record. THIS PAGE IS NOT THE FULL NOTICE OF PRIVACY PRACTICES. The full notice is available upon request. In addition to our longstanding commitment to protecting your information, there are certain obligations we have under federal law. One of those obligations is to provide you with this Notice.

THINGS EXPLAINED IN THE FULL NOTICE OF PRIVACY PRACTICES

- **How we may use and share your health information without your permission to:**
  - Provide treatment to you
  - Get paid for the services we provide to you
  - Make reports to federal, state, and local agencies and others when the law requires such reporting
  - Make reports or share information for public health, safety, and/or research purposes.

- **How we can share your information without your permission, but only if we give you a chance to object:**
  - To share information about you to family, friends, or others involved in your care for payment for the services you receive
  - To share information in case of a disaster to let your family and friends know where you are and your general condition

- **How we can use and share your medical information only with your permission for disclosures other than those described above.**

- **Your legal rights under federal privacy laws include your right to:**
  - Ask to see and copy your medical information
  - Ask that incorrect or incomplete information in your medical information be corrected
  - Ask for a list of the places we have sent your information unless it was sent with your permission, for payment, treatment, or health care operations
  - Ask that we communicate with you in a confidential manner
  - Ask for a paper copy of the Notice of Privacy Practices at any time
  - Be notified in the event of a breach of unsecured, protected health information
  - File a complaint if you think your privacy rights have been violated