Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address (please print or stamp)	**Dentist's/Dental Hygienist's Signature**
The Smile Lodge **713 Pierce Road** **Clifton Park, NY 12065**	

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

CHILD CARE AUTHORIZATION

I, _____, the parent or guardian of the below named minors, and legally entitled to give this authorization, grant temporary authority to _____, limited to the below defined powers, over the following children:

_____

_____

_____

_____

_____

The powers granted are limited to the following (please check):

- ☐ To supervise routine hygiene appointments and operative appointments with nitrous oxide
- ☐ To schedule routine hygiene appointments and operative appointments with nitrous oxide
- ☐ To authorize diagnostic x-rays when indicated
- ☐ To authorize varnish treatment when indicated
- ☐ To discuss with the doctor and office staff protected health information
- ☐ To discuss operative treatment and review nitrous oxide when indicated
- ☐ To sign treatment informed consent forms for treatment
- ☐ To review post-operative instructions and care for the child post operatively
- ☐ To authorize treatment plan changes if recommended by the doctor at the time of the procedure

This grant of authority is effective as of _____ and shall remain in effect until terminated by the undersigned parent or guardian.

This grant of authority is signed this _____ day of _____ in the County of _____, in the State of New York.

Signed,

_____
Legal Guardian

RECORDS RELEASE REQUEST

713 PIERCE ROAD
CLIFTON PARK, NY 12065
(518) 373-1181 FAX: (518) 373-0130
WWW.SMILELODGE.COM

PATIENT'S NAME (PLEASE PRINT): _____

DATE OF BIRTH: _____

DESCRIPTION OF RECORDS YOU WISH TO ACCESS: _____

_____

_____

☐ I WISH TO SEE THE REQUESTED RECORDS
☐ I WISH TO RECEIVE A COPY OF THE REQUESTED RECORDS
☐ I WISH TO AUTHORIZE A RELEASE OF THE REQUESTED RECORDS TO THE BELOW NAMED PARTY

NAME: _____

ADDRESS: _____

TELEPHONE: _____

☐ I WISH TO AUTHORIZE A RELEASE OF THE REQUESTED RECORDS (VIA SECURE E-MAIL) TO THE ADDRESS LISTED BELOW

E-MAIL: _____

☐ I WISH TO AUTHORIZE A RELEASE OF THE REQUESTED RECORDS TO THE FAX NUMBER BELOW: (PLEASE NOTE: X-RAYS CANNOT BE FAXED)

FAX: _____

I, _____HEREBY AUTHORIZE THE SMILE LODGE PEDIATRIC DENTISTRY TO RELEASE THE REQUESTED RECORDS OF THE PATIENT IDENTIFIED ABOVE, TO THE DESIGNATED NAME, ADDRESS OR E-MAIL.

_____ _____

{PLEASE PRINT NAME} {RELATIONSHIP TO PATIENT}

_____ _____

{SIGNATURE} {DATE}

PRIVACY OFFICIAL: JILLIAN VINCENT
713 PIERCE ROAD, CLIFTON PARK, NY 12065
TELEPHONE: (518) 373-1181

PLEASE CONTACT ONE OF OUR PRIVACY OFFICIALS LISTED ABOVE IF YOU HAVE ANY QUESTIONS REGARDING YOUR REQUEST TO INSPECT, TRANSFER, OR OBTAIN RECORDS.

AUTHORIZATION FOR RELEASE OF DENTAL X-RAYS

In order for your child to receive a thorough examination, obtaining current x-rays is crucial. We evaluate x-rays every day to aid in making appropriate treatment recommendations for our patients.

If we do not receive your child's most recent x-rays, we may recommend re-taking them. If their last set of x-rays were taken less than 12 months ago, re-taking them could result in an out of pocket cost to you. If we need to contact your child's previous dental office on the day of their appointment, this may extend the length of their appointment by 45 minutes. We understand that parents lead busy lives. By giving you prompt service, your child will be well on their way to a more healthy and beautiful smile. If your child's x-rays cannot be emailed from their previous dental office and your child's appointment is in less than two weeks, please obtain and **bring physical copies of the x-rays**.

Otherwise, please fill out the bottom portion of this form and send it to your child's previous dental office as soon as possible. We greatly appreciate your assistance and we look forward to seeing you!

----------(please cut here)----------

I, _____ hereby authorize and request the release of x-rays to
(PRINT – parent/legal guardian)
The Smile Lodge for my child, _____ (DOB: ___/___/_____).

Please either: Send a digital copy to: info@smilelodge.com (preferred)

OR

Mail to: The Smile Lodge
713 Pierce Rd.
Clifton Park, NY 12065

By authorizing to have digital copies sent, you take full responsibility that your child's private dental records are going to be sent over the internet. We need to receive the digital records in JPEG format.

Responsible Party: _____
(SIGNATURE - parent/legal guardian)

Relationship to patient: _____

Date: _____