



UB's ***S-MILES TO GO DENTAL PROGRAM*** will be visiting your child's school soon. If you do not have a dentist this is a great opportunity for your child to receive dental care during the school day.

WHAT IS IT?

The ***S-MILES TO GO DENTAL PROGRAM*** offers the following dental services to your children.

- A new 3 chair mobile dental office that will be parked at the school
- Examinations, x-rays, cleanings, sealants, fillings and other dental services
- Specially trained Pediatric and General Dentists
- If your child has dental insurance, the insurance carrier will be billed for these services described above. If you do not have dental insurance or cannot afford dental care, we have a sliding fee program to assist you. Our goal is to provide dental services to all regardless of ability to pay. Please call 716-829-6240 for information on the Sliding Fee Program.

HOW DOES IT WORK?

- Complete the attached consent form. Please include insurance information and check just one box indicating the services you wish your child to receive. Don't forget to sign the form.
- Medicaid, Child Health Plus and Family Health Plus Insurances will be billed for services and are accepted as payment in full.
- Dental screening and oral health education are provided at no charge to you and a screening report form will be sent home.
- Treatment is provided to your child during the school day on the *S-Miles To Go* unit or in the school with portable dental equipment.
- Parents are welcome to attend the appointment but it is not necessary.

WHAT'S NEXT?

○ **YES, I want my child to receive dental care** If yes, to sign your child up for the S-miles To Go mobile dental program please complete the attached paperwork and return it to your child's teacher as soon as possible.

○ **NO, I do not want my child to receive dental care, my child sees a dentist regularly.**

Child's Name: _____ Grade _____ Teacher _____

If **No**, Please return this form to your child's teacher to avoid further communication. Thank You!

QUESTIONS?

- Contact Paula Fischer at UB at 716-829-6240 or pmfische@buffalo.edu

Poor oral health can lead to decreased school performance, poor social relationships and less success later in life. Children experiencing oral pain are distracted and unable to concentrate on schoolwork UB Dental is here to help your child succeed.



DENTAL CONSENT FORM CONTINUED (IN ORDER FOR US TO TREAT YOUR CHILD, YOU MUST SIGN BELOW INDICATING YOU HAVE READ AND AGREE TO THE FINANCIAL RESPONSIBILITIES AND CONSENT FOR TREATMENT)

- I understand that by signing this form, I am consenting for the child named above to receive a dental examination, bitewing and/or panoramic x-rays as needed, dental cleaning, brushing / flossing instructions, fluoride treatment, sealants, fillings, crowns, extractions and pulpal therapy as needed.
- The risks associated with treatment are: accidental biting or scratching of the lip/cheek by the child if local anesthesia is used and /or slight discomfort, bleeding and /or swelling.
- If no treatment is provided, the following may occur: undetected dental/oral disease (cavities, gum disease etc.), which may lead to pain, swelling, and/or infection.
- I understand that this consent may stay in effect for one school year while my child attends this school.
- I understand that it is my responsibility to inform the dental provider and/or the school nurse of any changes in my child's medical information.
- I understand that all information about my child will be kept confidential. I have read and agree to the Notice of Privacy Practices.

Notice of Privacy Practices:

<http://dental.buffalo.edu/content/dam/dental/Pictures/Patients/Patient%20Privacy%20Information/NPP%20v%201.5%2001-15%20Final.pdf>

- If your child needs specialty care (sedation), you will be notified and referred to the UB School of Dental Medicine or a provider in your area.
- I further consent that my child's medical doctor and/or school official may release any medical information to the UB Dental staff that may affect his/her dental treatment. In addition, if a dentist is noted above, I understand that any dental findings/treatment shall be forwarded to that provider.
- Photographs may be taken for educational purposes. I hereby grant the University at Buffalo School of Dental Medicine permission to use the likeness of my child in a photograph or other digital reproduction in any and all of its publications, including website entries, without payment or any other consideration. If No, check here

By signing this form, I give consent for treatment and agree to the Financial Responsibilities previously listed.

Forms that do not have a parent/guardian's signature will be returned

Parent/Guardian Signature:

_____ Date ___ / ___ / ___

YOUR CHILD CANNOT BE SEEN FOR DENTAL CARE UNLESS THE ABOVE INFORMATION IS RECEIVED If you need assistance completing this form please call Sarah at 716-397-2640

