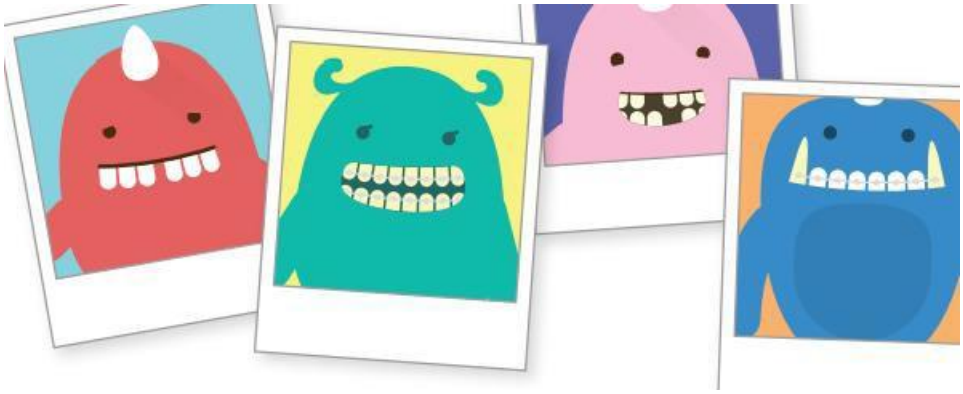
DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Bureau of Oral Health and Dental Services

Smile Check Wants to Connect with You Virtually!



In past years, the Delaware Smile Check Program has enjoyed completing dental screenings at schools across the state and performing preventive services for students on site. This year, however, we may not get to see everyone's smiling faces right away, as the COVID-19 pandemic has rearranged plans for back to school. If your school can't offer in person dental screenings at this time, don't worry! There are still lots of things to smile about.

The Smile Check Virtual Program is being offered to students that have Medicaid, CHIP, or no dental insurance. *Sign up today,* by completing the forms attached.

E-mail: Smile_Check@delaware.gov

Contact the Bureau of Oral Health and Dental Services if you need assistance.

Phone: 302-622-4540

Oral Health Education	• **Offered remotely via Zoom or your school's virtual platform** • **Includes age appropriate material including why teeth are important, nutritional counseling, how to brush, floss and prevent cavities, and how oral health relates to overall health**
Screening Assessment Survey	• **Questionnaire completed by parents/guardians that lets our professional dental team know how we can assist your child and family**
Personalized Case Management	• **Customized connections to care for each child, including urgent referrals and routine preventive treatment** • **Your child will be matched with a dental health coordinator to personally, help you access any resources you need**

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Delaware Smile Check Program

A School-Based Oral Health Initiative

Student Information

First Name:_____ **Last Name:**_____ **Gender** (*check*): ☐ **M** ☐ **F**

Race *(check any that apply)*:
- ☐ Asian
- ☐ Native American
- ☐ Black/African American
- ☐ American Indian or Alaska Native
- ☐ White
- ☐ Hispanic/Latino
- ☐ Other:_____

This is a federal requirement.

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Birthdate (*month/day/year*)**:**_____ **School:** _____

Grade:_____**Teacher:**_____

Dental Insurance *(check):* ☐ **MEDICAID** ☐ **CHIP** ☐ **No Insurance**

Delaware Medicaid/CHIP dental ID number: _____

Does the child have a dentist? (*check*): ☐ **YES** ☐ **NO**

Dentist's Name *(if yes above)*: _____

You will be contacted by a Community Dental Health Coordinator after the screening assessment is reviewed. To talk about any dental concerns you have, answer questions, assist you with barriers to care, and discuss oral health concerns and recommendation.

Parent/Legal Guardian Information:

Name:_____ **Cell phone:** _____ **Other #**_____

Email: _____ **Relationship to child:**_____

Name:_____ **Cell phone:** _____ **Other #**_____

Email:_____ **Relationship to child:** _____

I would like to receive dental resources and information for my child and family via email (*check):*

☐ **YES** ☐ **NO**

What is the best time and ways to contact you? *(check all that apply)*

☐ **CALL** ☐ **TEXT** ☐ **EMAIL** ☐ **VIDEO**

What is the best time of day to reach you?: _____**am** _____**pm**

By submitting this consent, I hereby certify that the above information is true and complete. This program is only available to students who have Medicaid, CHIP or are uninsured. You will not be billed for any service received. Insurance will be billed to Medicaid and CHIP for screening and case management. All screening results and data are strictly confidential and will only be shared with a legal guardian.

Parent/Legal Guardian Name: _____**Date:** _____

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Public Health

CONSENT FOR EXAMS-TESTS-TREATMENT-SERVICES-RELEASE OF HEALTH & INSURANCE INFORMATION

YOUR NAME: _____ **CHILD'S NAME:** _____

PATIENT'S Date of Birth _____ **(MM/DD/YYYY)**

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

This consent indicates that you or your child may be examined, have appropriate tests, receive treatments and/or minor procedures, receive referrals and/or receive any other services by a person authorized by the Division of Public Health, (DPH). You have reviewed the DPH policy on chaperones and discussed it with the children.

You certify that you are ***(check one)*** ☐ **Client** ☐ **Parent** ☐ **Legally Authorized Representative**

CONSENT TO PARTICIPATE IN HEALTH INFORMATION EXCHANGE

Receipt of Notice of Patient Privacy Practices (Acknowledgment)
By submitting this Agreement, you acknowledge the Notice of Patient Privacy Practices.

Health Information Exchange-
Delaware's Health Information Exchange Network, (DHIN), allows health care providers to share health care information about patients' electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. Understand that if you go to a Delaware Health & Social Services (DHSS) or Division of Public Health, (DPH) facility, staff may get a copy of health care information electronically through the information exchange connections with other health care providers.

By submitting this consent, you consent to the use and release of all health care information for treatment , payment and health care operations, among the affiliated entities of the Delaware Health & Social Services , Notice of Patient Privacy Practices, as amended from time to time.

ADDITIONAL INFORMATION TO BE EXCLUDED: _____

Assignment of Benefits and Medical Records release to Delaware Health and Social Services, Division of Public Health• Submitting this consent gives authorization for the following: any insurance benefits are to be paid directly to DHSS; the release of pertinent medical information to insurance carriers; the responsibility to pay for non-covered services; to release and hold harmless the State of Delaware, DHSS/ DPH and its agents and/or staff from any liability for any injuries suffered as a result of any exams, test, treatment, and/or services rendered; the consent to taking samples, cultures, or lab tests that they deemed necessary; the chance to correct and change information to make sure it is correct and complete; to know what information is being disclosed.

I have read this form and/ or if requested, had it read to me. Any disclosure of my Protected Health Information (PHI) carries with it the potential for disclosure by the recipient and the PHI may not be protected by the Federal Privacy rules.

This consent shall apply to all Division of Public Health Services for a period of one year from the date of submission and can be revoked, in writing, at any time.

Please note receiving family planning services is not a prerequisite for you to receive any other services offered by DPH.

_____

Printed Name of Patient/ If Under 18 Printed Name of Legal Guardian — Date

_____

Printed Name of Staff/Agent — Date

Student Name:	Date of Birth:	Screening Assessment
Parent/Guardian Name:	School:	Ages 6 -12

Has your child received dental care by a dentist in the last 12 months?

☐ Yes | ☐ No ☐ Not Sure

Does your drinking water have fluoride?

☐ Yes | ☐ No ☐ Not Sure

Does your child take a fluoride supplement prescribed by a dentist or physician?

☐ Yes | ☐ No ☐ Not Sure

If yes, what type?

_____

Has your child complained about any of the following in last 6 months? *Check all that apply.*

☐ Pain or senstivity when eating or drinking
☐ Mouth or tooth pain that is worse at night
☐ Difficulty biting hard foods
☐ Difficulty in chewing
☐ Fever
☐ Ear pain

Has your child ever had or used any of the following? *Check all that apply.*

☐ Cavities
☐ Tooth pulled
☐ Root canal or crown
☐ Cleft Palate
☐ Teeth whitening products
☐ Mouth Guard
☐ Braces
☐ Thumb sucking appliance

Has your child missed any school due to dental pain?

☐ Yes | ☐ No ☐ Not Sure

Look in your child's mouth, do you or your child see any of the following? *Check all that apply*.

☐ Dark or white spots on the teeth
☐ Bumps or blisters around gums or in mouth
☐ Red or bleeding gums
☐ Teeth that are visibly crooked, crowded or stick out
☐ A baby tooth that has an adult tooth coming in behind or under the baby tooth

How many teeth can you count in your child's mouth?

Number of teeth**:**_____

Does your child use toothpaste to clean their teeth?

☐ Yes | ☐ No ☐ Not Sure

Does your child use any of the following? *Check all that apply*

☐ Toothpaste that has fluoride
☐ Electric toothbrush
☐ Waterpik
☐ Fluoride mouth rinse

What is your child's favorite:

Drink?_____

Snack?_____

Meal?_____

Does your child do any of the following? *Check all that apply.*

☐ Grind Teeth
☐ Play a sport
☐ Vaping, Juuling, E-Cigarettes
☐ Smoke or chew tobacco

Is your child anxious about going to the dentist?

☐ Yes | ☐ No ☐ Not Sure

Who has given you the best information about oral health (teeth and mouth)? *Check all that apply*

☐ Family/friends ☐ Doctors office
☐ Internet ☐ Dentist office
☐ School ☐ Social Worker
☐ Teacher ☐ Other _____
☐ Community Health Worker/ Home Visitor

How often does your child brush their teeth?

☐ Never ☐ A few times a week
☐ One time a day ☐ More than once a day

When does your child normally brush their teeth? *Check all that apply.*

☐ Morning before breakfast
☐ Morning after breakfast
☐ After each meal
☐ Before going to bed

How often does your child floss their teeth?

☐ Never
☐ A few times a month
☐ A few times a week
☐ One time or more daily

Does an adult supervise or help your child when brushing and flossing teeth?

☐ Yes | ☐ No ☐ Not Sure

What type of problems would prevent you from taking your child to the dentist? Check all that apply.

☐ Finding a dentist
☐ Financial
☐ Reliable Transportation
☐ Anxiety
☐ Finding Time
☐ Special Needs
☐ Language Barrier
☐ Health Concern
☐ Cultural Beliefs
☐ Other:_____

Medical conditions can affect oral health. Does your child have any of the following?

☐ Asthma
☐ Diabetes
☐ Heart Condition
☐ Autoimmune disorder
☐ Eating Disorder (Anorexia, Bulimia, Pica)
☐ Mood Disorder (Depression, Bipolar

Has your child missed any school due to dental pain?

☐ Yes | ☐ No ☐ Not Sure

Are there other children or adults in the household who have not been to the dentist in 12 months?

☐ Yes | ☐ No ☐ Not Sure

If yes, how many?

Adults: _____ Age_____
Children: _____ Age_____

What oral health information would you find helpful?

☐ Tips to stay in good oral health
☐ Finding the right dentist for you (specialty, location, language, culture, gender, etc.)
☐ Understanding my dental benefit
☐ Help with enrolling with Medicaid
☐ Help with finding dental insurance
☐ How dental and medical health are connected
☐ Transportation to the dentist
☐ HPV vaccination to prevent oral, cervical cancer
☐ Mental health and oral health
☐ Diabetes and oral health care
☐ Check list for when your child needs a dental visit, physical, vaccination, vision, and hearing
☐ What to do for a toothache
☐ What is a dental emergency and where to go
☐ Mouth protection for sports
☐ How to quit smoking
☐ When should my child see and orthodontist?
☐ Other_____