MONTOURSVILLE AREA SCHOOL DISTRICT

Nurses

High School	McCall	Lyter	Loyalsock Valley
570-368-2611	570-368-2441	570-368-2614	570-435-0446

Dear Parent/Guardian,

We are pleased to share that our school district has once again partnered with River Valley Health & Dental to offer in-school dental services through their Mobile Dentist Program. This program provides students with convenient access to dental care - including cleanings and restorative treatment - without leaving school.

This is a valuable opportunity for your child to receive quality dental care during the school day, saving you time and helping your child avoid missing class. If you would like your child to participate in this program, please contact the nurse for more information.

Thank you for your attention and continued support.

Sincerely,

Montoursville Area School District Nurses

River Valley Health
Where Care Meets Compassion

Dental School Program

River Valley Health provides dental services to students within local school districts. Students enrolled will be seen by staff at their respective school on our mobile unit. Any student within the district is eligible for the program.

Dental Services Provided:

- Dental Exams
- Dental X-Rays (Cavity Detection X-Rays)
- Instructions for Oral Hygiene, Brushing, Flossing, and Diet
- Fluoride Varnish Treatments
- Prophylaxis (Dental Cleanings)
- Sealants
- Silver Diamine Fluoride (SDF) - a topical fluoride used to treat and prevent dental caries and relieve tooth sensitivity. **Please note:** *This will stain/discolor the caries brown or black.*
- Restorative Treatment (Dental Fillings)-Treatment to restore the tooth structure resulting from caries or external trauma. **This is based on dentist availability.** All families will have the ability to schedule appointments at our other locations for additional care as needed.

Communication is a very important aspect provided to the parent(s)/guardian(s) of students enrolled in the Dental School Program. Notification is given prior to all appointments and follow-up calls are made by River Valley Health staff which include information regarding referrals and/or additional treatment needed. An evaluation for is also mailed out after ever appointment to inform you of services completed.

*Enrollment forms must be **completely filled out** in order to serve the students. These forms will collect insurance information and services will be billed accordingly. The responsible party is expected to pay the balance, if any, after insurance. If you do not have insurance, we offer a sliding fee scale discount program which discounts services based on income and household size using the Federal Poverty Guidelines.

If you are interested in enrolling your child(ren) in the program, please fill out the attached enrollment and consent form and return them to the school.

Laura Bierly, RDH, PHDHP
Registered Dental Hygienist/Program Coordinator
570-567-5400 ext. 1320
laurab@rivervalleyhealthpa.org

UNITED WAY
North Central
Pennsylvania

This program is funded in part by the United Way of North Central Pennsylvania.

River Valley Health
Where Care Meets Compassion

Dental School Program Enrollment Form

(PLEASE PRINT)

Patient's Last Name:_____First Name:_____MI: _____

Sex:_____Date of Birth:_____Social Security #:_____

Address (Include Apt. #):_____City: _____State:_____

Zip Code: _____Pharmacy: _____School Child Attends:_____Grade_____

# of Persons in Household:_____Monthly Household Income: _____

DENTAL INSURANCE CARRIER:_____POLICY NUMBER:_____

Housing Status:
- ☐ Not Homeless
- ☐ Doubling Up
- ☐ Homeless Shelter
- ☐ Public Housing
- ☐ Street
- ☐ Transitional

Race:
- ☐ White
- ☐ Black/African American
- ☐ Native Hawaiian American
- ☐ Indian/Alaska Native
- ☐ Other Pacific Islander
- ☐ Declined to Answer

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Chinese
- ☐ German
- ☐ Italian
- ☐ Japanese
- ☐ Other
- ☐ Sign Language

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Declined to Answer

MEDICAL HISTORY: (Please attach additional sheet if needed)

Surgeries/Hospitalizations: _____

Illnesses: _____

Medications: _____

Allergies: _____

Primary Care Provider:_____Date of Last Visit:_____

PARENT/GUARDIAN CONTACT INFORMATION:

NAME: _____

PHONE:_____SECONDARY PHONE: _____

EMAIL ADDRESS: _____

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

UNITED WAY
North Central
Pennsylvania

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River Valley Health
Where Care Meets Compassion

Dental School Program
Consent for Treatment

Patient (Child's) Name: _____ Date of Birth: _____

This authorization and consent is intended to cover the delivery of dental care services to my minor child (referenced above) by River Valley Health.

- I understand that this authorization will remain in effect with no expiration, unless revoked. I may revoke this authorization at any time, following the procedures outlined in the River Valley Health **Notice of Privacy Practices.**
- I understand that by signing this authorization, I am giving River Valley Health the authority to provide treatment, including administration of medication, as necessary in the provider's judgment.
- I understand that the practice of medicine is not an exact science, and no person has made a guarantee about the outcome of such care.
- I reserve the right to refuse specific treatment at any time.

By signing below, I hereby consent to treatment by all River Valley Health providers, staff and others that may be involved in the dental care of my child in ways they judge are beneficial, to include but not limited to dental exams, dental cleanings, dental x-rays, fluoride varnish, restorative care, sealants, and silver diamine fluoride (a topical fluoride used to treat and prevent dental caries and relieve tooth sensitivity which will stain/discolor the caries brown or black). Further, I understand that such treatment may be provided outside of my physical presence by signing this consent.

I understand I have full access to the following documents at any time online at www.rivervalleyhealthpa.org:

- River Valley Health Notice of Privacy Practices
- Patient Rights and Responsibilities

At any time, I can request a hard copy of these documents by calling River Valley Health.

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

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

Relationship to Patient: _____

River Valley Health Williamsport Medical and Dental
471 Hepburn Street, Williamsport, PA 17701
570-567-5400