

WVU Children's Dental Program

Who is eligible? Any child who has active Medicaid or WV CHIP insurance

What services are provided (depending on date of last dental visit)?

- Dental Exams and Screenings
- Cleanings
- Fluoride Varnish Treatment
- Sealants (when necessary)
- Referral to a dental home

A sealant is a plastic resin coating that is "painted" onto a tooth's chewing surface. It acts as a barrier to protect the enamel from plaque and acids. Sealants can reduce cavities by 70%.

Who will provide the services? Lisa Dunn Poland, Dentist
Rebecca Campbell, Registered Dental Hygienist
Rhonda Hull, Registered Dental Hygienist
Staci Freeman, Registered Dental Hygienist
WVU Children's Dental Program
WVU Health Sciences Center, Eastern Division
2500 Foundation Way, Martinsburg, WV 25401
304-596-6321

Where are services provided? At your child's school

Cost to parents: Costs are completely covered by Medicaid and/or WV CHIP insurance.
There is no cost to you.

For more information and a listing of actual school dental program dates go to:

<http://www.hsc.wvu.edu/eastern/Child-Dental-Care.aspx>

HOW TO ENROLL: Fill out the other side of this form and return to homeroom teacher

WVU CHILDREN'S DENTAL PROGRAM

Patient Registration Form

Only children with active Medicaid or active WV Chip are eligible for this program.

CHILD'S Name _____
LAST
FIRST
MIDDLE

CHILD'S Date of Birth _____ Age _____
Month – Day – Year of Child's Birth

Social Security Number _____ - _____ - _____ Male _____ Female _____

Child's PO Box or Street Address _____

City _____, WV Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

School child will be attending: _____ Grade _____

Medicaid number (11 digits) _____

WV Chip number (10 digits) _____

Does the child have any allergies or medical conditions? _____ Yes _____ No

If yes, please list: _____

I declare that the information that I have given is correct to the best of my knowledge, I understand that it will be held in strict confidence and it is my responsibility to inform this office of any changes in my child's medical status. By signing below, I give my permission to the dental staff to perform any or all of the following as deemed necessary during the school year: dental exam, screening, dental images, cleaning, fluoride treatment, and sealants.

PARENT, please PRINT YOUR NAME here _____

PARENT Signature _____ Date _____

| DO NOT WRITE BELOW – FOR DENTAL OFFICE USE ONLY | | | | |
|---|-----------------|-----------------|-----------------|-----------------|
| | Visit 1 | Visit 2 | Visit 3 | Visit 4 |
| | Scion Medi Chip | Scion Medi Chip | Scion Medi Chip | Scion Medi Chip |
| Last seen WVU | | | | |
| For What Pvt Dent | | | | |

For What _____

Perform Services: