Teledentistry

Your child can receive dental services without missing school!

Dental Services Provided

- Oral Health Screening
- Dental X-Rays
- Teeth Cleaning
- Fluoride and Sealant Application
- Oral Hygiene Kit
- Oral Home Care Education
- Referral for Follow-up Services

Tips for Healthy Teeth

1. Brush twice a day for two minutes with a soft bristle toothbrush.
2. Floss at least once a day.
3. Visit a dentist every six months for a regular checkup, starting at the age of one year.
4. Eat a well-balanced diet, and limit sugary and acidic foods/drinks.
5. Consider a nightly fluoride rinse to help prevent cavities.

Southeast Health District
Office of Oral Health
www.sehdph.org/teledentistry

1101 Church Street
Waycross, GA 31501
(912)287-4893

GEORGIA DEPARTMENT OF PUBLIC HEALTH
Southeast Health District

Georgia Department of Public Health
Southeast Health District

Southeast Health District
OFFICE OF TELEDENTISTRY
1101 Church Street, Waycross, Georgia 31501
Phone: 912-287-4893 Fax: 912-287-6657

Rosemarie D. Parks, M.D., M.P.H.
District Health Director

August 2023

Dear Parent/Guardian,

The **Southeast Health District (SEHD) Teledentistry Program** is ready for the 2023-2024 school year. **Teledentistry is NOT a mobile van or bus clinic**. Our clinic is located inside the elementary school. Please read carefully to determine if our program is an option for your child.

The Teledentistry program offers preventive visits during the school day. We provide an oral health screening, dental x-rays, prophy (cleaning), fluoride varnish, sealants (if recommended), oral home care instructions, treatment plan with referral (as needed), an oral hygiene kit for home use, and follow up services with the hygiene coordinator to assist in finding dental treatment (if recommended).

Our supervising dentist, along with Augusta University Dental College of Georgia, provide oversight to the program by utilizing videoconferencing technology. Your dental insurance provider will be filed for services performed.

The teledentistry clinic is located in your child's school. If your child does not attend the school where the clinic is located, he/she may be transported by school bus to the clinic. The SEHD team works closely with the school transportation department and school nurse in your county for scheduling.

Your child's dental record will be maintained by SEHD and can be shared with a dental office, as requested. If your child is treated in the teledentistry clinic, his/her records are reviewed by the advising dentist to create a screening treatment plan. You will receive a referral letter from the SEHD Teledentistry Program, via the school, soon after your child's visit to the clinic. Along with the referral letter, you will receive a resource list of dental providers that currently accept your insurance. Please use this guide to find a dental provider for your child, if applicable. The providers on this list may change their acceptance status of your insurance at any time. You may find additional help or new additions by calling your insurance provider. You will also receive a follow up phone call a few weeks from the date of service to further assist with seeking treatment.

If your child does **NOT** have a local dentist, the SEHD Teledentistry Program contracts with a local dentist in Waycross whom we can refer your child to for dental treatment, if recommended.

The SEHD Teledentistry Program wants your child to have a healthy mouth and a successful school year. By seeking the recommended dental treatment, you can increase the likelihood of both. Our team is looking forward to seeing your child in the teledentistry clinic. If you have questions or concerns about our program please call Kayla Daniels, RDH or Veronica Zavala, RDA at 912-287-4893. You may also contact your child's school nurse.

Appling	Bulloch	Coffee	Tattnall
Atkinson	Candler	Evans	Toombs
Bacon	Charlton	Jeff Davis	Ware
Brantley	Clinch	Pierce	Wayne

SOUTHEAST HEALTH DISTRICT - TELEDENTISTRY: MEDICAL/DENTAL HISTORY 2023-2024

PLEASE FILL IN ALL SPACES (PLEASE PRINT) - SIGN/DATE BELOW

CHILD'S LEGAL NAME: (FIRST) _____ (MIDDLE) _____ (LAST) _____

PREFERRED NAME: _____ **WHAT TIME IS BEST TO CONTACT YOU:** _____

PARENT/GUARDIAN'S NAME: _____ **RELATIONSHIP TO PATIENT:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

BIRTHDATE: _____/_____/_____ **AGE:** _____ **GENDER:** _____ **PLACE OF EMPLOYMENT:** _____

PHONE NUMBERS: (CELL) _____ (HOME) _____ (WORK) _____

SCHOOL ATTENDING: _____ **HOMEROOM TEACHER:** _____ **GRADE:** _____

CHILD'S CURRENT DENTIST & DATE OF LAST VISIT: _____

ETHNIC BACKGROUND: □ ASIAN □ BLACK □ HISPANIC □ WHITE □ OTHER/MULTIPLE/UNKNOWN

WHAT IS THE PRIMARY SOURCE OF DRINKING WATER AT HOME (NO BOTTLED)? □ **CITY (PUBLIC) WATER** □ **WELL WATER**

PLEASE ANSWER THE FOLLOWING QUESTIONS *PROVIDE DETAILS FOR ANY "YES" ANSWERS

YES **NO** DOES YOUR CHILD TAKE ANY MEDICATIONS ON A REGULAR BASIS AND FOR WHAT CONDITIONS? **(*LIST ALL MEDS)**

_____

_____

YES **NO** IS YOUR CHILD ALLERGIC TO ANY MEDICATION/FOOD/OTHER? **(*IF YES, EXPLAIN)** _____

_____

YES **NO** HAS YOUR CHILD EVER HAD PROBLEMS WITH PREVIOUS DENTAL TREATMENT? **(*IF YES, EXPLAIN)** _____

_____

YES **NO** HAS YOUR CHILD RECENTLY BEEN SUFFERING FROM DENTAL PAIN/SWELLING/PROBLEMS? **(*IF YES, EXPLAIN)**

_____

YES **NO** IS THIS YOUR CHILD'S FIRST DENTAL EXPERIENCE?

****INSURANCE INFORMATION:** (PLEASE INDICATE THE INSURANCE COMPANY THE PATIENT IS COVERED BY)

***MEMBER ID # ON CARD:** _____ **EFFECTIVE DATE:** _____

***MEDICAID ID # ON CARD (if different):** _____

□ GA MEDICAID

□ FL MEDICAID

□ AMERIGROUP/DENTAQUEST

□ CARESOURCE/SCION

□ PEACHSTATE/ENVOLVE

□ WELLCARE/AVESIS

□ NO INSURANCE COVERAGE

□ OTHER/PRIVATE/UNKNOWN INSURANCE:
(*Please list)

_____

TOTAL NUMBER OF PERSONS LIVING IN HOUSEHOLD: _____ **TOTAL HOUSEHOLD MONTHLY GROSS INCOME: $** _____

***PARENT/GUARDIAN (SIGNATURE):** _____ **DATE:** _____

- ANEMIA
- ANXIETY
- ARTIFICIAL JOINTS/VALVES
- ASTHMA
- ATTENTION DEFICIT DISORDER (ADD, ADHD) ***IS MED TAKEN DAILY?** _____
- AUTISM
- BLEEDING EASILY/EXCESSIVELY
- BLOOD DISEASE/DISORDER
- BLOOD TRANSFUSION
- BONE DISORDER
- BRAIN DISORDER
- CANCER
- CEREBRAL PALSY
- CHEMOTHERAPY TREATMENT
- COLD SORES/FEVER BLISTERS
- DIABETES ***TYPE?** _____
- DOWN SYNDROME
- EAR/NOSE/THROAT CONDITION
- EPILEPSY * **WITH SEIZURES?** _____
- FAINTING/DIZZINESS
- FOOD ALLERGIES
- EYE DISORDER/GLAUCOMA
- HEADACHES **(FREQUENT)**
- HEART CONDITION **(CIRCLE ALL THAT APPLY:)** (IRREGULAR HEARTBEAT/ARTIFICIAL HEART VALVE/HEART MURMUR/HEART SURGERY/ OTHER: _____)
- HEMOPHILIA/BLEEDING TENDENCY
- HEPATITIS ***TYPE?** _____
- HIGH BLOOD PRESSURE
- HIV POSITIVE/AIDS
- JAUNDICE
- KIDNEY DISEASE
- LEUKEMIA
- LIVER DISEASE
- LOW BLOOD PRESSURE
- MENTAL DISABILITY
- MUSCLE DISORDER
- OPPOSITIONAL DEFIANT DISORDER (ODD)
- PREGNANT
- PREMEDICATION NEEDED ***EXPLAIN:** _____
- PSYCHIATRIC CARE
- RASH/HIVES
- RADIATION TREATMENT
- RESPIRATORY/BREATHIING PROBLEM
- RHEUMATIC FEVER
- SCARLET FEVER
- SCOLIOSIS
- SEIZURES **(NOT ASSOC. WITH EPILEPSY)** ***EXPLAIN:**_____
- SICKLE CELL ANEMIA
- SKIN DISEASE
- SPEECH PROBLEM
- SPINA BIFIDA
- STD(s)
- STOMACH DISORDER/INTESTINAL PROBLEMS/ULCERS
- THYROID DISEASE
- TUBERCULOSIS
- TUMORS/GROWTHS

☐ **NO KNOWN HEALTH CONDITIONS (*CHECK HERE IF YOUR CHILD DOES NOT HAVE ANY HEALTH PROBLEMS)**

➢ **PLEASE EXPLAIN EACH CONDITION YOU HAVE CHECKED ABOVE AND LIST ANY MEDICATIONS. IT IS VITAL THAT WE HAVE A COMPLETE & ACCURATE MEDICAL HISTORY, AS IT HAS A DIRECT IMPACT ON THE PATIENT'S ORAL HEALTH.**

_____
_____
_____
_____
_____
_____

***PARENT/GUARDIAN (SIGNATURE):** _____ **DATE:** _____

Georgia Department of Public Health
Southeast Health District

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OFFICE OF TELEDENTISTRY
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CONSENT FOR TELEDENTISTRY SERVICES 2023-2024

* I hereby authorize the Southeast Health District, affiliated associates, and contracted persons to perform preventive & restorative dental services on my child including: dental screening, exam, radiographs, photographs, intraoral pictures, prophy(cleaning), fluoride varnish, restorative treatment, sealants, patient education, and case management.

* I authorize the Southeast Health District, affiliated associates, and contracted persons to verify and bill insurance coverage & eligibility by acquiring employment, financial, medical history & other related matters deemed necessary for billing purposes.

* I authorize the Southeast Health District to bill the patient's insurance provider for services provided in the Teledentistry clinics and affiliated/contracted associates offices.

* I authorize and approve the release & disclosure of my child's medical/dental records maintained by the Southeast Health District affiliated associates, contracted persons, and other healthcare/dental providers, as requested by a healthcare/dental provider or the parent/guardian.

* I will contact the Southeast Health District Teledentistry staff with any changes that may occur to my medical/dental history or record while participating in the program at 912-287-4893.

* I am aware of and understand the Ware County Board of Health notice of privacy practices and can view it at https://www.sehdph.org/services/teledentistry.

* I have read & agree to the terms above & have provided true and accurate information concerning the patient and myself to the best of my knowledge.

CHILD/PATIENT NAME: (PRINT) _____

PARENT/GUARDIAN NAME: (PRINT) _____

PARENT/GUARDIAN SIGNATURE: _____

TODAY'S DATE: _____/_____/_____

Appling	Bulloch	Coffee	Tattnall
Atkinson	Candler	Evans	Toombs
Bacon	Charlton	Jeff Davis	Ware
Brantley	Clinch	Pierce	Wayne

PARENT QUESTIONNAIRE – TELEDENTISTRY 2023-2024

PLEASE COMPLETE ALL OF THE QUESTIONS BELOW TO THE BEST OF YOUR KNOWLEDGE. THIS INFORMATION ALLOWS US TO COLLECT DATA CONCERNING ORAL HEALTH KNOWLEDGE AND TO TRACK CURRENT BARRIERS FAMILIES FACE WHEN SEEKING DENTAL TREATMENT IN RURAL AREAS. THANK YOU FOR YOUR PARTICIPATION.

1. How would you rate the health of your child's teeth/mouth?

□ Excellent □ Good □ Fair □ Poor

2. How often has your child complained of dental pain/problems/swelling in the past year?

□ Never □ Sometimes □ Often

3. Approximately how long ago did your child visit a dentist? (not including the school program)

□ 6 months ago or less □ 6 mo-1 year ago □ 1-2 yrs ago □ more than 2 yrs ago □ Never

4. Why did your child last visit a dentist?

□ Cleaning/checkup □ Dental pain/problem □ Treatment of a previously diagnosed problem
□ Never □ Other, explain: _____.

5. If your child needed dental treatment and did NOT receive it, what is the primary reason? (please choose one answer best suited to your case)

□ Financial issue □ Transportation issue □ Fear/Anxiety □ Cannot take off work/school
□ Cannot find a dental provider that accepts my insurance □ Forgot
□ Other, explain: _____.

6. How often does your child brush their teeth?

□ 1x morning only □ 1x night only □ 2x (once morning and once night) □ More than 2x day

7. How often do you supervise/assist your child when brushing their teeth?

□ Never □ Sometimes □ Often

8. How many times a day does your child consume sugary/acidic snacks or drinks BETWEEN meals? (ex. Candy, chips, juice, sweet tea, sports/energy drinks)

□ Never □ 1x day □ 2x day □ 3x or more day

9. How often does your child use a fluoride rinse, tablet, or drop at home?

□ Never □ Sometimes □ Often

10. Has your child ever had a dental screening/cleaning in their school Teledentistry clinic? (you would have received a referral letter, via school, and an attempted follow-up phone call from our program)

□ Yes □ No

11. If yes to question #10, please rate your family's experience with the Teledentistry program.

□ Excellent □ Good □ Fair □ Poor

12. What county does your child attend school in?

□ Brantley □ Charlton □ Clinch

13. Do you have any recommendations or suggestions for improvement concerning our program?

_____.