

Teledentistry



Your child can receive dental services without missing school!

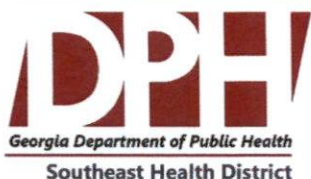
Dental Services Provided

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




Tips for Healthy Teeth

1. Brush twice a day for two minutes.
2. Floss at least once a day.
3. Visit a dentist every six months.
4. Eat a well-balanced diet and limit sugar.
5. Add a nightly fluoride rinse to repair enamel.



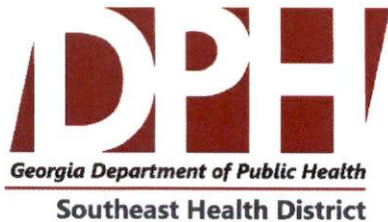
More Information

Southeast Health District

912-287-4893 

Office of Oral Health - Waycross 

www.sehdph.org/services/teledentistry 



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 2025

Dear Parent/Guardian,

The **Southeast Health District (SEHD) Teledentistry Program** is ready for the 2025-2026 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. If your child has a current dentist, we ask they remain a patient at their dental home and omit signup.

The Teledentistry program offers preventive visits during the school day. We provide an oral health screening/exam, dental x-rays, prophylaxis (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 to assist in finding dental treatment (if recommended). 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.

Our supervising dentist, along with Augusta University Dental College of Georgia, provide oversight to the program by utilizing videoconferencing technology. The SEHD team works closely with the school transportation department and school nurse in your county for scheduling. Teledentistry interactions are not equivalent to an in-person clinical examination and the dentist may not be physically present during some services.

If your child is treated in the teledentistry clinic, his/her records are reviewed by the advising dentist. You will receive a phone call and/or a referral letter from the SEHD Teledentistry Program soon after your child's visit to the clinic to further assist with seeking a dental provider for treatment, if needed. Your dental insurance provider may be billed for services performed. You may find additional help by calling your insurance provider.

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 contact Kayla Daniels, RDH or Veronica Zavala, DA at 912-287-4893. You may also contact your child's school nurse.

Thank you for allowing us to provide oral care to your child!

Appling
Atkinson
Bacon
Brantley

Bulloch
Candler
Charlton
Clinch

Coffee
Evans
Jeff Davis
Pierce

Tattnall
Toombs
Ware
Wayne

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SOUTHEAST HEALTH DISTRICT - TELEDENTISTRY:
MEDICAL/DENTAL HISTORY

2025-2026



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

CHILD'S PREFERRED NAME: _____ CHILD'S BIRTHDATE: _____ CHILD'S CURRENT AGE: _____

CHILD'S GENDER: FEMALE MALE WHEN IS BEST TO CONTACT YOU: MORNING AFTERNOON EVENING ANYTIME

PARENT'S/LEGAL GUARDIAN'S NAMES GIVING CONSENT: _____

RELATIONSHIP TO CHILD OF ABOVE NAMES (ALL THAT APPLY): MOTHER FATHER OTHER: _____

NAMES OF SIBLINGS ATTENDING SCHOOL IN SAME HOUSEHOLD: _____

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

PHONE NUMBERS: (CELL) _____ (HOME) _____ May we text you? _____

SCHOOL ATTENDING: _____ HOMEROOM TEACHER: _____ GRADE: _____

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

ETHNIC BACKGROUND: ASIAN BLACK HISPANIC WHITE OTHER/MULTIPLE/UNKNOWN N/A

1. WHAT IS THE SOURCE OF YOUR KITCHEN SINK TAP/COOKING WATER AT HOME? CITY (PUBLIC) WATER WELL WATER

2. DOES YOUR CHILD TAKE ANY MEDICATIONS AND FOR WHAT MEDICAL CONDITIONS? (*IF YES, EXPLAIN) YES NO

3. IS YOUR CHILD ALLERGIC OR SENSITIVE TO ANY MEDICATION/FOOD/OTHER? (*IF YES, EXPLAIN) YES NO

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

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

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

*INSURANCE COMPANY NAME: _____

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

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

GA MEDICAID

PRIVATE INSURANCE COVERAGE

FL MEDICAID

NO INSURANCE COVERAGE

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

****Please check all that apply and sign:**

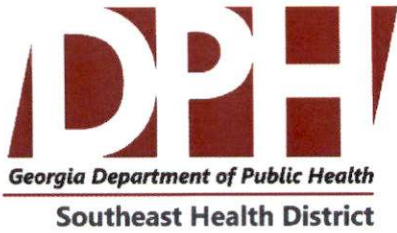
- ANEMIA
- ANXIETY
- ARTIFICIAL JOINTS/VALVES
- ASTHMA
- ATTENTION DEFICIT DISORDER (ADD, ADHD) ***IS MED TAKEN DAILY?** _____
- AUTISM
- BLEEDING EASILY/EXCESSIVELY
- BLOOD DISEASE/DISORDER
- BONE DISORDER
- BRAIN DISORDER
- CANCER ***CURRENT OR REMISSION?**
- CEREBRAL PALSY
- CHEMOTHERAPY TREATMENT
- 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: _____)
- 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) ***IS MED TAKEN DAILY?** _____
- PREGNANT

- PREMEDICATION NEEDED
***EXPLAIN:** _____
- PSYCHIATRIC CARE
***EXPLAIN:** _____
- 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
- STROKE
- THYROID DISEASE
- TUBERCULOSIS
- TUMORS/GROWTHS

➤ **PLEASE EXPLAIN EACH CONDITION YOU HAVE SELECTED 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.**

****Initial here if your child does NOT have any known health issues (none of the conditions were selected):** _____

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



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

CONSENT FOR TELEDENTISTRY SERVICES 2025-2026

* I hereby authorize the Southeast Health District (Ware County Board of Health), affiliated associates, and contracted persons to perform preventive & restorative dental services on named patient including, but not limited to: dental screening, exam, radiographs, photographs, prophylaxis (cleaning), fluoride varnish, treatment, sealants, patient education, and case management. Authorizing Dentist: Dr. Jonathan Drawdy, DMD, #DN011282. Referral Dentist: Dr. Page Manus, DMD, #DN010411. 410 Uvalda St. Waycross, GA. 912-283-3542. Hygienist: Kayla Daniels, RDH, #DH010892.

* I authorize the Southeast Health District, affiliated associates, contracted persons to verify and bill insurance, & eligibility by acquiring employment, financial, medical history & other related items 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 associates' offices.

* I understand that Teledentistry interactions are not equivalent to an in-person clinical examination and that the dentist shall not be physically present during some services. It is my responsibility to have my child seen in person at least annually, recommended by our dentists.

* 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>. My signature signifies that this agreement is valid for one year from the date signed.

* 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 on all forms. I am a legal parent or guardian. I can request a copy of my signed forms at any time.

CHILD/PATIENT NAME: (PRINT) _____

PARENT/GUARDIAN NAME: (PRINT) _____

PARENT/GUARDIAN: (SIGNATURE) _____

TODAY'S DATE: _____/_____/_____

Appling
Atkinson
Bacon
Brantley

Bulloch
Candler
Charlton
Clinch

Coffee
Evans
Jeff Davis
Pierce

Tattnall
Toombs
Ware
Wayne

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PARENT QUESTIONNAIRE – TELEDENTISTRY 2025-2026

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 outside of school?

- 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 about appointment
 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 when not eating meals)

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

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

- Never Sometimes Often

10. Has your child ever had a dental screening/cleaning in their school Teledentistry clinic?

- Yes No Unsure

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

- Excellent Good Fair Poor N/A

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?

_____.