all smiles
community oral health

在您小孩学校提供的免费牙科服务

重要的：请把签好名的同意书送回来以便使用这项免费服务。

- **服务包括：**
- 免费牙科筛检 – *我们的牙科专业人士会查看学生的口腔，检查牙齿和牙龈的整体健康状况。*
- 免费牙科密封剂 – *放在学生后牙上用于防止龋齿（蛀牙）的涂层。*
- 免费氟化物 – 这种“维生素”刷在牙齿上会让牙齿更牢固，防止龋齿。

为何您应该帮您的小孩登记使用这项免费服务：

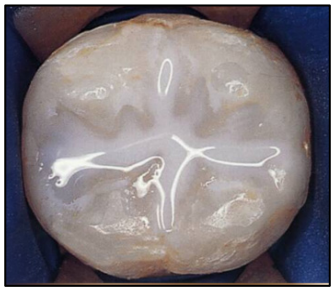
- 健康的牙齿对人的整体健康来说很重要。
- 如果在学校上牙科密封剂，您耽误工作、小孩耽误上学的时间都较少。
- 是由专业牙科护理人士来上牙科密封剂。
- 请每年至少看一次牙医。

氟化物是用一把小刷子涂刷在牙齿上的。

欲知详情，请拨打：
503-521-7166。

用牙科密封剂前

用牙科密封剂后



问题：龋齿

- 龋齿是最常见的儿童疾病。
- 在 5-11 岁的小孩中大约有 50% 的小孩至少有一颗蛀牙[1]。

解决方案：牙科密封剂

- 用牙科密封剂的学生比不用牙科密封剂的学生龋齿少 50%[2]。
- 涂氟化物能预防 43% 的恒齿龋齿及 37% 的乳齿龋齿[3]。

[1] *CDC（美国疾病控制中心）。Children's Oral Health（《儿童牙科健康》）。https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html#:~:text=More%20than%20half%20of%20adolescents,one%*

[2] *Community Preventive Services Task Force (社区预防服务工作组)。(2017 年) Improving Oral Health: （《改善口腔健康：在学校为提供牙科密封剂的计划》）。https://www.thecommunityguide.org/sites/default/files/assets/OnePager-OralHealth-School-Sealants.pdf*

[3] *作者：Marinho VCC、Worthington HV、Walsh T、Clarkson JE. 用于预防儿童和青少年龋齿的氟化物透明涂层。Cochran Database of Systematic Reviews（Cochran 系统评价数据库）2013 年第 7 期。文章编号：CD002279. DOI: 10.1002/14651858（一周 7 天、一天 24 小时）*

2023 年 5 月修订

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FREE DENTAL SERVICES AT YOUR CHILD'S SCHOOL

Important: Please return a signed permission slip to use this free service.

Free services include:

- Dental screening: Our dental professional looks in the student's mouth to check the health of teeth and gums.
- Dental sealants: Coatings may be put on the student's back teeth to prevent cavities.
- Fluoride: Brushed on teeth, this vitamin makes teeth stronger and prevents cavities.

Why you should sign your child up for free services:

- Healthy teeth are important to your overall health.
- When dental sealants are done in school you miss less work and your child misses less school.
- Dental sealants are done by dental care professionals.
- See your dentist at least once a year.

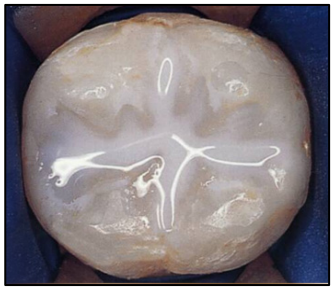
Fluoride is put onto teeth with a small brush.

For more information, please call us at

503-521-7166.

Before Sealant

After Sealant



The Problem: Cavities

- Cavities are the most common childhood disease.
- About 50% of children aged 5-11 years have at least one cavity[1].

The Solution: Dental Sealants

- Students who receive sealants have 50% fewer cavities than students who do not[2].
- Fluoride application prevents 43% of cavities in permanent teeth and 37% of cavities in baby teeth[3].

1 CDC. Children's Oral Health. https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html#:~:text=More%20than%20half%20of%20adolescents,one%

2 Community Preventive Services Task Force. (2017) Improving Oral Health: School-Based Dental Sealant Delivery Programs. https://www.thecommunityguide.org/sites/default/files/assets/OnePager-OralHealth-School-Sealants.pdf

3 Marinho VCC, Worthington HV, Walsh T, Clarkson JE. Fluoride varnishes for preventing dental caries in children and adolescents. Cochran Database of Systematic Reviews 2013, Issue 7. Art. No: CD002279. DOI: 10.1002/14651858

Revised May 2024

提供免费牙科服务的同意书

您孩子的学校提供免费牙科评估、牙科密封剂、氟化物涂刷。这些服务由专业牙科护理人士提供并且有助于防止蛀牙。

孩子姓名：_____
（姓氏） （名字） （喜欢用的名字）

孩子的出生日期（年/月/日）：_____/_____/_____老师：_____ 年级：_____

学校：_____

请勾选下面的一个方框来登记使用这项免费服务：

- ☐ **好，请提供牙科评估、牙科密封剂和氟化物**
- ☐ **好，请提供牙科评估和牙科密封剂**
- ☐ **好，请提供牙科评估和氟化物**
- ☐ **好，请仅提供牙科评估**

*** 注：若不止勾选了一个方框，将提供所有获批的服务。**

☐ **不，请不要为我的孩子提供任何牙科服务**

联系信息	
父母/监护人：	首选语言：
最常用的可以联络到您的电话号码：	允许发送短信： ☐ 是 ☐否
电子邮件地址：	
邮寄地址：	

请提供以下信息，以便我们更好地为您的孩子服务：

我的孩子正在服用（列出药物名称）：	无：☐
我的孩子对以下物质过敏：	无：☐
目前出现的健康问题：	无：☐
有哪些行为方面的考虑：	无：☐
有助于我们更好地为您孩子服务的其他信息：	无：☐

请完整填写以下部分的内容。不会向您收取任何费用。

医疗保险： ☐ Oregon Health Plan (OHP) / Medicaid ID 号 _____ ☐ **私人牙科保险公司** _____ ☐ **无医疗保险**	这些服务**免费！**

作为合法家长/监护人，本人同意在 24 个月内，在牙科密封剂工作人员、学校工作人员、保险公司、孩子的牙医、适用的协作保健组织和/或有记录的牙医保健组织之间发布和共享信息，包括个人健康信息。本人已收到一份“隐私惯例通知”副本，隐私惯例可于 All Smiles Community Oral Health 网站 AllSmilesCOH.org/forms 上获取。我明白，牙科学生可在持牌专业人员的密切监督下提供治疗。

父母/监护人签名：_____ **日期：**_____

Revised May 2024

Permission Slip for Free Dental Services

Free dental screenings, sealant placements, and brushed-on fluoride are offered at your child's school. These services are done by dental care professionals and will help prevent cavities.

Name of Child: _____
(Last) (First) (Preferred Name)

Child's Date of Birth (mm/dd/yy): _____ /_____ /_____Teacher: _____ Grade: _____

School: _____

Check <u>ONE BOX</u> below to sign up for this free service:

- ☐ Yes, to screening, sealants and fluoride
- ☐ Yes, to screening and sealants
- ☐ Yes, to screening and fluoride
- ☐ Yes, to screening only

* NOTE: If more than one "yes" box is checked, all approved services will be provided.

☐ **NO, do not provide any dental services for my child**

Contact Information	
Parent/Guardian:	Preferred Language:
Best phone number to reach you:	Permission to Text: ☐ YES ☐NO
Email address:	
Mailing address:	

Please provide the following information so we can better serve your child:

My child is taking (list medications):	None: ☐
My child is allergic to:	None: ☐
Any current medical conditions:	None: ☐
Any behavioral considerations:	None: ☐
Other information to help us better serve your child:	None: ☐

Please complete the section below. You will not receive a bill.

Health Insurance: ☐ Oregon Health Plan (OHP) / Medicaid ID# _____ ☐ Private dental insurance company _____ ☐ No health insurance	These services are **FREE!**

As the legal parent/guardian, I consent for 24 months to the release and sharing of information, including personal health information, between the dental sealant staff, school staff, insurance carriers, the child's dentist, applicable Coordinated Care Organization, and/or the Dental Care Organization of record. I have received a copy of "Notices of Privacy Practices," also available on the All Smiles Community Oral Health website AllSmilesCOH.org/forms. I understand that a dental student closely supervised by a licensed professional may provide treatment.

Parent/Guardian Signature: _____ Date: _____

隐私惯例通知概要

对您的受保护的健康信息（亦称作医疗记录）进行保密，是 All Smiles Community Oral Health 的首要任务。我们可能由于许多原因需要使用有关信息或向他人作出披露。本隐私惯例通知旨在向您告知我们可以使用和发布您医疗记录信息的方式。本页并非隐私惯例通知的全文。通知全文可应要求提供。除恪守承诺保护您的信息外，根据联邦法律，我们还需要履行若干义务。其中一项义务便是向您提供本通知。

隐私惯例通知全文所述事项

- **我们如何在未获得您许可的情况下使用和分享您的健康信息以：**
  - 向您提供治疗。
  - 就我们向您提供的服务获得付款。
  - 按照法律规定向联邦、州和地方机构等作出报告。
  - 就公共健康、安全及/或研究目的作出报告或分享信息。

- **除非我们给予您机会提出异议，否则我们如何在未获得您许可的情况下分享您的信息以：**
  - 向参与您护理的家人、朋友或其他人分享有关您的信息，以就您收到的服务获得付款。
  - 发生不幸时分享信息，以让您的家人和朋友了解您在哪里及您的一般情况。

- **我们如何仅在获得您许可的情况下使用和分享您的医疗信息以作出上文所述以外的披露。**

- **联邦隐私法赋予您的法定权利包括以下权利：**
  - 要求查看和复制您的医疗信息。
  - 要求改正您医疗信息中的不准确或不完整信息。
  - 要求我们为付款、治疗或健康护理业务的目的而发送您信息的地点列表，经您允许的发送者除外。
  - 要求我们限制我们为治疗、付款或健康护理业务的目的而使用或分享的信息，或我们与参与您护理的家庭成员或其他人分享的信息。
    我们无须同意您的请求
  - 要求我们以保密的方式与您沟通。
  - 随时要求获取隐私惯例通知纸质副本。
  - 在无担保、受保护的健康信息遭违反时获得通知。
  - 在您认为您的隐私权遭侵犯时提出控告。
  - 全额自付健康护理项目或服务费用，并限制向您的健康计划提供者披露该特定的项目或服务。

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The confidentiality of your protected health information, also called your medical record, is a high priority at All Smiles Community Oral Health. There are a number of reasons we may need to use this information or disclose it to others. This Notice of Privacy Practices is provided to inform you of the ways we can use and release information from your medical record. THIS PAGE IS NOT THE FULL NOTICE OF PRIVACY PRACTICES. The full notice is available upon request. In addition to our longstanding commitment to protecting your information, there are certain obligations we have under federal law. One of those obligations is to provide you with this Notice.

THINGS EXPLAINED IN THE FULL NOTICE OF PRIVACY PRACTICES

- **How we may use and share your health information without your permission to:**
  - Provide treatment to you.
  - Get paid for the services we provide to you.
  - Make reports to federal, state, and local agencies and others when the law requires such reporting.
  - Make reports or share information for public health, safety, and/or research purposes.

- **How we can share your information without your permission, but only if we give you a chance to object:**
  - To share information about you to family, friends, or others involved in your care for payment for the services you receive.
  - To share information in case of a disaster to let your family and friends know where you are and your general condition.

- **How we can use and share your medical information only with your permission for disclosures other than those described above.**

- **Your legal rights under federal privacy laws include your right to:**
  - Ask to see and copy your medical information.
  - Ask that incorrect or incomplete information in your medical information be corrected.
  - Ask for a list of the places we have sent your information unless it was sent with your permission, for payment, treatment, or health care operations.
  - Ask that we limit the information we use or share for treatment, payment, or healthcare operations, or the information we share with family members or others involved in your care. We are not required to agree to your request.
  - Ask that we communicate with you in a confidential manner.
  - Ask for a paper copy of the Notice of Privacy Practices at any time.
  - Be notified in the event of a breach of unsecured, protected health information.
  - File a complaint if you think your privacy rights have been violated.
  - Pay out of pocket in full for a healthcare item or service and restrict disclosure of that particular item or service to your health plan provider.