all smiles
community oral health

健康牙齿涂氟

重要的： 如欲享受该免费服务，请交回已签字的许可单。

将在您孩子的学校免费提供牙齿涂氟和牙科筛查。

牙科筛查即快速查看您孩子的口腔内部，检查牙齿的整体健康状况。牙齿涂氟是在牙齿上刷上保护涂层。

欲了解更多信息，请拨打我们的电话 **503-521-7166**。

您需要了解的内容：

- 牙齿涂氟是保护牙齿免受蛀牙侵害的一种安全快速的方法。
- 牙齿涂氟无害。
- 筛查和牙齿涂氟由牙科护理专业人士进行。

保持健康的微笑

- 每天刷牙。
- 使用米粒大小的含氟牙膏。
- 选择健康的零食，如水果和蔬菜。
- 尝试喝水而不是果汁。
- 健康的乳牙将有助于预防成年牙齿出现问题。
- 至少每年到牙医处看诊一次。

Revised May 2023

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Fluoride Varnish for Healthy Teeth

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

Free fluoride varnish and dental screenings are offered at your child's school!

A dental screening is a quick look inside your child's mouth to check the overall health of their teeth. Fluoride varnish is a protective coating brushed on the teeth.

For more information, please call us at **503-521-7166.**

What you need to know:

- Fluoride varnish is a safe and quick way to protect teeth from cavities.
- Fluoride varnish does not hurt.
- Screenings and fluoride varnish are done by dental care professionals.

Keeping a healthy smile:

- Brush and floss every day.
- Use fluoride toothpaste the size of a grain of rice.
- Choose healthy snacks such as fruits and vegetables.
- Try drinking water over juice.
- Healthy baby teeth will help prevent problems in adult teeth.
- See a dentist at least once a year.

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免费牙科筛查/牙齿涂氟计划许可单

现正在您孩子的学校提供免费的牙科筛查和牙齿涂氟服务。牙齿涂氟是保护牙齿免受蛀牙侵害的一种快速简单的方法。筛查和牙齿涂氟由牙科护理专业人士进行，每年最多四次。

孩子姓名：_____
（姓氏） （名字） （喜欢用的名字）

孩子的出生日期（年/月/日）：_____/_____/_____

学校：_____

牙科筛查：快速查看您孩子的口腔内部，检查牙齿的整体健康状况。

☐ 是 ☐ 否

牙齿涂氟：应用于牙齿以预防蛀牙。

☐ 是 ☐ 否

如果选择"是"，请完整填写下列内容并签字：

联系信息	
家长/监护人姓名：	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，本人兹此同意包括与所提供服务有关的任何相关个人健康信息在内的信息供牙科工作人员、Head Start 工作人员、您孩子的未来学区或 ESD、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进行发布和交流使用。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。本人亦了解可由牙科卫生或护理专业学生在取得执照的牙科专业人士的密切监督下提供治疗服务。

父母/监护人签名：_____ **日期：**_____

Внимание: эта форма доступна на русском языке по адресу AllSmilesCOH.org/forms
Chú ý:Mẫu này có sẵn bằng tiếng Việt tại tại nha AllSmilesCOH.org/forms
注意：此表格可通過以下網址獲得中文版本: AllSmilesCOH.org/forms

Revised May 2024

Free Dental Screening/Fluoride Varnish Program Permission Slip

Free dental screenings and fluoride varnish services are now offered at your child's school. Fluoride varnish is a quick and easy way to protect teeth from cavities. The screening and fluoride varnish are done by dental care professionals up to four times a year.

Child's Name: _____
(Last) (First) (Preferred Name)

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

School: _____

Dental Screening: A quick look inside the mouth to check the overall health of teeth.

☐ YES ☐ NO

Fluoride Varnish: Applied to teeth to prevent cavities.

☐ YES ☐ NO

If Yes, Please Complete and Sign Below:

Contact Information	
Parent/Guardian Name:	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 problems:	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 hereby consent to the release and exchange of information, including any relevant personal health information regarding the services provided, between the dental staff, Head Start staff, your child's future school district or ESD, 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." Privacy Practices are available on the All Smiles Community Oral Health website AllSmilesCOH.org/forms. I also understand a dental hygiene or nursing student closely supervised by a licensed dental professional may provide treatment.

Parent/Guardian Signature:_____ Date: _____

Внимание: эта форма доступна на русском языке по адресу AllSmilesCOH.org/forms
Chú ý: Mẫu này có sẵn bằng tiếng Việt tại tại nha AllSmilesCOH.org/forms
注意：此表格可通過以下網址獲得中文版本: AllSmilesCOH.org/forms

Revised May 2024

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.