REGIONAL
CAPE COD
Technical High School

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William P Terranova
Principal

Jonathan W Roberts
Assistant Principal

Annie L Dolan-Niles
Technical Studies Director

Dear Parents/Guardians of Cape Cod Tech Students:

Cape Cod Regional Technical High School is proud to announce that Polished, LLC, a program that provides preventative dental care, will once again be offering free dental services to the students in our school. After watching this team in action, I highly recommend that every student take advantage of this free program.

They will provide these dental services to all students, whether or not they have dental insurance.

The following dental services will be provided:

- ✓ Dental cleaning
- ✓ Sealants (as needed)
- ✓ Fluoride varnish application
- ✓ Toothbrush and toothpaste
- ✓ Referrals to local dentists
- ✓ Temporary fillings if needed

These services will be provided by Public Health Hygienists and/or Dentists. A report will be issued to Mrs. Maurukas, the School Nurse, and forwarded on to you as soon as possible. You will be contacted immediately if your child requires urgent dental care.

Attached you will find a two-sided form to be completed by you and returned to the School Nurse immediately. Once you return this form to Mrs. Maurukas, she will schedule two appointments (one in the fall and one in the spring) for your child. Please consider signing your child up for this convenient free service.

Please visit www.polishedteeth.com to see the dates that the dental team will be in our school.

Sincerely,

Gretchen Wahtola, RN

Gretchen Wahtola, RN
School Nurse

Polished, LLC Health History

Child's Information (Please print):

Child's Name: _____ _____ M ☐ F ☐ **Child's Birthday:** ____/____/____
(first) (last) (month) (day) (year)

School: _____ Grade: _____ Room: _____ Teacher: _____

Child's primary language: _____ Parent's primary language: _____

Parent's name and address: _____

Email _____ Parent's day time phone: _____

Dental Information:

1. Date of last dental check-up: _____
2. My child has a local dentist YES ☐ NO ☐ Dentist name: _____
   If not, we will provide a list of dentists in your area.
3. My child needs to take antibiotics before having dental treatment ☐YES Why? _____ ☐ NO
4. Please tell us about your child's dental experience. _____

Medical Information:

1. My child has had serious health problems YES ☐ NO ☐
2. My child is under a doctor's care now. YES ☐ for _____ NO ☐
3. My child has now or had before: Anemia ☐ Asthma ☐ Convulsions ☐ Diabetes ☐ Epilepsy ☐Seizures☐ Glaucoma ☐ Heart Problems:☐ Heart Murmur ☐ Heart valve replacement ☐Hepatitis ☐ Kidney/ Liver ☐ Rheumatic Fever ☐ Joint replacement ☐ Immune Disorder /HIV/ AIDS ☐ Tuberculosis☐ Other: _____
4. My child is taking medicine YES ☐ name of medicine _____ NO ☐
5. My child is allergic to: Penicillin☐ Antibiotics ☐ Aspirin ☐ Latex ☐ Foods ☐ Other: _____

Other Demographic Information:

The following information is for the Commonwealth of Massachusetts.

My child is: Black/ African American ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐
Native Hawaiian/ Pacific Islander ☐ Hispanic ☐ More than one race ☐
I do not wish to answer ☐

Insurance Information

My child has the following dental insurance:

☐ **No Dental Insurance**

☐ **MassHealth** RID Number: _ _ _ _ _ _ _ _ _ _ _ _ _

☐ **Delta** ☐ **BC/BS** ☐ **Other** _____

Individual Policy# _____

Group Policy # _____

Subscriber Information

Subscriber Name: _____ Subscriber ID: _____

Subscriber _____ Employer Name: _____ Subscriber Date of Birth: Month_ _ Day_ _ Year_ _ _ _

I agree that the above health information is correct.
I give permission for Polished LLC to provide preventive care, to confirm insurance and bill my insurance for care provided. Polished LLC will make every attempt to NOT impact your regular dental checkups, by checking claims history prior to billing for any services. Contact: Ellen Gould RDH MPA email: polishedcheckin@gmail.com; phone (508) 237-5378.

SIGN HERE Parent/Guardian:

▶ _____ **Date:** _____