Bland Ministry Center
FOOD PANTRY • CLOTHES CLOSET • DENTAL CLINIC • HOME REPAIR

8487 SOUTH SCENIC HIGHWAY
BLAND, VA 24315
276-688-4711

Dear Parent or Guardian,

Bland Ministry Center (BMC) is partnering with area schools to improve access to dental services for children. Tooth decay is the most common chronic disease in children. Dental disease accounts for one million lost school hours in Virginia each year.

BMC has arranged to provide dental services for all children. These services may include an exam, x-rays, a cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). A licensed dentist, hygienist, and assistants will come to your child's school with portable equipment twice per year.

Bland Ministry Center is a "Smiles for Children" and "Delta Dental" dental provider. What does this mean?
We are accepting Medicaid, Famis, Famis Plus, and Delta Dental Insurances. There is no out-of-pocket charge to parents for the visit; insurance will pay for the visit and treatment, if applicable, or grant funding will cover expenses for all other students.

TELL-SHOW-DO technique is often used to gain the confidence and cooperation of the dental patient. The dental provider explains what they are going to do, then shows what they are going to do with instruments on a model. The provider makes every effort to be a partner in care with the patient and family, making the dental visit pleasant and informative.

INFORMED CONSENT indicates your awareness of sufficient information to allow you to make an informed personal choice concerning the patient's dental treatment. Most patients do not encounter any difficulties with their treatment. If the patient indicates any strong resistance to the dental procedure, we will discontinue the treatment.

The dental team at Bland Ministry Center is happy to be able to provide these services.
Please call our office (276-688-4711) with any questions you have.

**If you currently take your child to see a dentist every 6 months for routine care,
we encourage you to continue to seek care at that office, and you do not need to complete this form.**

**For your child to receive these services, you must provide ALL THE INFORMATION requested and SIGN in the area indicated ON THE FOLLOWING PAGES.
If your child has participated in previous years, you still need to complete this packet for the 2023-24 school year.**

Thank you,

Dr. Vincent Filanova, DD

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PATIENT INFORMATION: (complete all sections)

School: _____ Gender: _____

Child's Legal Name: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____

PARENT / GUARDIAN INFORMATION:

P/G Name: _____

Relationship to student: _____

Email: _____

Best Contact Phone #: _____

Alternate Contact #: _____

The following information is required for Grant Reports, allowing us to enhance our services.

___ American Indian or Alaska Native

___ Asian

___ Black or African American

___ Native Hawaiian or other Pacific Islander

___ White

___ Other Race

___ Unreported / Declined to report

___ More than one race

ETHNICITY: (circle one)

Hispanic / Non-Hispanic / Decline to report

MEDICAL INFORMATION (complete all sections)

Does your child take any medications on a routine basis? ___ YES ___ NO

List:_____

_____

___

Physician: _____

Does your child have allergies?

___ YES ___ NO

— Seasonal _____

— Antibiotics _____

— Latex _____

— Medication _____

— Food _____

— Other _____

Does your child currently have a dental home?

___ YES ___ NO

Dentist's name: _____

Date of last visit: _____

Does your child need antibiotics before dental treatment? If so, please explain:

_____

_____

____

INSURANCE INFORMATION
(if applicable)

Is your child enrolled in the Medicaid / Smiles for Children Program?

___ YES ___ NO

Does your child have DELTA DENTAL insurance?

___ YES ___ NO

If yes, please complete the following information for the primary enrollee.

Enrollee's name: _____

Address (if different from child):

Street or PO Box: _____

City/State/Zip: _____

Best Contact #: _____

Alternate Contact #: _____

Date of Birth: _____

Insurance ID or SS#: _____

Insurance Co. Phone #: _____

Insurance Co. Address: _____

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Wythe County Public Schools and our participating Dental Offices would like to offer dental services to your child. Our goal is to help your child achieve good oral health and empower them with the knowledge to maintain and sustain it. We can provide a basic visual screening only or provide some basic dental care, which may include the following procedures:

Dental cleaning
Fluoride application
Radiographs (x-rays) as necessary
Application of sealants to dental fissures
Referrals to our clinic for restoration of decayed or broken teeth, treatment of infected teeth or gums, or simple extractions.

PARENT/GUARDIAN SIGNATURE REQUIRED IF SERVICES ARE WANTED.

I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described, even though I am not present, and allow the school nurse, school representative, and dental provider access to the child's dental record.

To the extent permitted by law, I consent to the use and disclosure of the minor's protected health information to carry out payment activities in connection with this claim. I hereby authorize and direct payment of the dental benefits directly to Bland Ministry Center Dental Clinic.

CHILD'S NAME: _____

PARENT/GUARDIAN NAME: _____

RELATIONSHIP TO CHILD: _____

SIGNATURE OF PARENT / LEGAL GUARDIAN: _____

TODAY'S DATE: _____