

Parkview Medical Clinic - Fluoride Varnish Consent

PLEASE READ THIS FORM BEFORE YOU SIGN

We are following new guidelines for our well child visits and the Minnesota Department of Health is encouraging us to apply a fluoride varnish for children at higher risk for dental caries or who do not regularly see a dentist.

This service is available to all patients in the appropriate age range. Your child is in the appropriate age-range, but the decision for your child to have a fluoride varnish applied is up to you.

If your child has Medicaid for insurance, this service is covered at 100%. If you have private insurance, your insurance may or may not pay for this service. If your insurance does not pay for this or you do not have insurance, this service will be your responsibility.

Children who regularly see the dentist are already getting fluoride applications and are encouraged to get these performed at the dentist.

What is Fluoride Varnish?

- A dental treatment that prevents and slows tooth decay (cavities)
- A coating brushed on the surfaces of the teeth

Benefits of Fluoride Varnish:

- Reduced risk of cavities (caries)
- Treatment of early stages of tooth decay
- Reduced tooth sensitivity

Risks of Fluoride Varnish:

- Allergic reaction
- Sores in the mouth
- Nausea or vomiting if swallowed
- Temporary yellow discoloration of teeth (this is unlikely)

If you do not want your child to get fluoride varnish at today's visit, simply return this form (unsigned) to the front desk.

If you opt to have fluoride varnish applied for your child, please sign this consent form and give to the nurse. Please note this consent form is good for up to 1 year from today's date for any fluoride varnishes performed in the next year.

BY SIGNING BELOW:

- **You understand the risks/benefits of fluoride varnish application**
- **You understand that Medicaid patients will have zero cost for this service**
- **You understand that if your insurance does not pay for this service, or if you do not have insurance, you are responsible of the cost which is \$35**

Patient Name: _____

Today's Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____