Southeast Health District

Teledentistry

Dental Services Provided

- Oral Health Screening
- Dental Prophy (Cleaning)
- Dental Pictures and X-rays
- Oral Home Care Education
- Oral Hygiene Kit
- Fluoride and Sealant Application
- Referral for Follow-up Services

Southeast Health District

912-287-4893

Office of Oral Health

www.sehdph.org/services/teledentistry

Georgia Department of Public Health

DPH
Georgia Department of Public Health
Southeast Health District

Georgia Department of Public Health
Southeast Health District

Southeast Health District
OFFICE OF TELEDENTISTRY
1101 Church Street, Waycross, Georgia 31501
Phone: 912-287-4893 Fax: 912-367-1096

Rosemarie D. Parks, M.D., M.P.H.
District Health Director

Dear Parent/Guardian,

The Southeast Health District (SEHD) Teledentistry Program is ready for the 2026–2027 school year. Our public health program has a dental clinic located inside your elementary school and provides preventive dental care during school hours. If your child attends a partnering school, we will coordinate scheduling with the school nurse and transportation department to the school clinic.

Our services include:

- Oral health assessment
- Intraoral pictures and x-rays
- Dental prophylaxis (cleaning)
- Fluoride varnish application
- Sealants (if recommended)
- Oral hygiene education
- Take home oral care kit
- Referral to a dentist for treatment (if recommended)

During the visit, a supervising dentist oversees the program through secure videoconferencing. A dentist may not be physically present for all services. After your child's visit, we will contact you by phone and/or mail if follow-up care is recommended. Dental insurance may be billed for services provided and you may not incur a fee. If your child does not have a dentist, we may refer them to a local partnering dentist in Waycross for dental treatment.

We want your child to have a healthy smile and successful school year. If you have questions, please contact our Teledentistry office at **912-287-4893**, or speak with your school nurse.

Thank you for trusting us with your child's oral health.

Sincerely,

Kayla Daniels, RDH, Teledentistry Oral Health Coordinator

Appling	Bulloch	Coffee	Tattnall
Atkinson	Candler	Evans	Toombs
Bacon	Charlton	Jeff Davis	Ware
Brantley	Clinch	Pierce	Wayne

SOUTHEAST HEALTH DISTRICT - TELEDENTISTRY: MEDICAL/DENTAL HISTORY

2026-2027

Georgia Department of Public Health
Southeast Health District

***If your child has a current dentist, please do not complete this form.**

CHILD'S LEGAL NAME: (FIRST)_____ (MIDDLE)_____ (LAST)_____

CHILD'S PREFERRED NAME: _____ **CHILD'S BIRTHDATE:** _____ **CHILD'S CURRENT AGE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBERS: (CELL)_____ (TEXT)_____ **CHILD'S GENDER:** □ FEMALE □ MALE

PARENT'S/LEGAL GUARDIAN'S NAMES GIVING CONSENT: _____

RELATIONSHIP TO CHILD OF ABOVE NAMES (ALL THAT APPLY): □ MOTHER □ FATHER □ OTHER: _____

NAMES OF SIBLINGS ATTENDING SCHOOL IN SAME HOUSEHOLD: _____

_____

SCHOOL ATTENDING: _____ **HOMEROOM TEACHER:** _____ **GRADE:** _____

DATE OF LAST DENTAL VISIT AND DENTIST'S NAME: _____

ETHNIC BACKGROUND: □ ASIAN □ BLACK/AFRICAN AMERICAN □ HISPANIC □ WHITE □ OTHER/DECLINED

WHAT IS THE SOURCE OF YOUR TAP/COOKING WATER AT HOME? □ CITY (PUBLIC) WATER □ WELL WATER

HAS YOUR CHILD RECENTLY BEEN SUFFERING FROM DENTAL PAIN/PROBLEMS? (EXPLAIN) □ YES □ NO

_____

_____

***INSURANCE**: (PLEASE INDICATE DENTAL INSURANCE INFORMATION- YOU WILL NOT INCUR CHARGES)

***INSURANCE COMPANY NAME:** _____

***MEMBER ID # ON CARD:** _____ **EFFECTIVE DATE:** _____

***MEDICAID ID # ON CARD (if different):** _____

□ GA MEDICAID

□ FL MEDICAID

□ PRIVATE INSURANCE COVERAGE

□ NO INSURANCE COVERAGE

***Incomplete forms will not be processed and may result in delays or denial.**

****Parent/Guardian Signature:** _____

1. DOES YOUR CHILD TAKE ANY MEDICATIONS AND FOR WHAT MEDICAL CONDITIONS? **(*IF YES, EXPLAIN)** □ **YES** □ **NO**

_____

_____

_____

2. IS YOUR CHILD ALLERGIC OR SENSITIVE TO ANY MEDICATION/FOOD/OTHER? **(*IF YES, EXPLAIN)** □ **YES** □ **NO**

_____

_____

_____

**PLEASE CHECK ALL THAT APPLY:

- o ANEMIA
- o ANXIETY
- o ARTIFICIAL JOINTS/VALVES
- o ASTHMA
- o ATTENTION DEFICIT DISORDER (ADD, ADHD) ***IS MED TAKEN DAILY?** _____
- o AUTISM
- o BLEEDING EASILY/EXCESSIVELY
- o BLOOD DISEASE/DISORDER
- o BONE DISORDER
- o BRAIN DISORDER
- o CANCER ***CURRENT OR REMISSION**?
- o CEREBRAL PALSY
- o CHEMOTHERAPY TREATMENT
- o DIABETES ***TYPE?** _____
- o DOWN SYNDROME
- o EAR/NOSE/THROAT CONDITION
- o EPILEPSY * **WITH SEIZURES?** _____
- o FAINTING/DIZZINESS
- o EYE DISORDER/GLAUCOMA
- o HEADACHES **(FREQUENT)**
- o HEART CONDITION **(CIRCLE ALL THAT APPLY:)** (IRREGULAR HEARTBEAT/ARTIFICIAL HEART VALVE/HEART MURMUR/HEART SURGERY/ OTHER: _____)
- o HEPATITIS ***TYPE?** _____
- o HIGH BLOOD PRESSURE
- o HIV POSITIVE/AIDS
- o KIDNEY DISEASE
- o LEUKEMIA
- o LIVER DISEASE
- o LOW BLOOD PRESSURE
- o MENTAL DISABILITY *_____
- o MUSCLE DISORDER
- o OPPOSITIONAL DEFIANT DISORDER (ODD) ***IS MED TAKEN DAILY?** _____
- o PREGNANT
- o PREMEDICATION NEEDED ***EXPLAIN:** _____
- o PSYCHIATRIC CARE ***EXPLAIN:**_____
- o RADIATION TREATMENT
- o RESPIRATORY/BREATHIING PROBLEM
- o RHEUMATIC FEVER/SCARLET FEVER
- o SCOLIOSIS
- o SEIZURES **(NOT ASSOC. WITH EPILEPSY)** ***EXPLAIN:**_____
- o SICKLE CELL ANEMIA
- o SKIN DISEASE/RASH/HIVES
- o SPEECH DISORDER
- o SPINA BIFIDA
- o STD(s)
- o STOMACH DISORDER/INTESTINAL PROBLEMS/ULCERS
- o STROKE
- o THYROID DISEASE
- o TUBERCULOSIS
- o TUMORS/GROWTHS
- o **OTHER NOT LISTED:_____

_____

**Parent/Guardian Signature: _____

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District Health Director

CONSENT FOR TELEDENTISTRY SERVICES 2026-2027

* I hereby authorize the Southeast Health District (Ware County Board of Health), affiliated associates, and contracted persons to perform educational, preventive, and restorative dental services on named patient including, but not limited to: dental screening, exam, radiographs, photographs, prophy(cleaning), fluoride varnish, treatment, sealants, patient education, and case management. Authorizing Dentist: Dr. Jonathan Drawdy, DMD, #DN011282. Referral Dentist: Dr. Page Manus, DMD, #DN010411. 410 Uvalda St. Waycross, GA. 912-283-3542. Hygienist: Kayla Daniels, RDH, #DH010892. Hygienist: Wendy Walker, RDH, #DH011024.

* I authorize the Southeast Health District, affiliated associates, contracted persons to verify and bill insurance, & eligibility by acquiring employment, financial, medical history & other related items deemed necessary for billing purposes. I authorize the Southeast Health District to bill the patient's insurance provider for services provided in the Teledentistry clinics and affiliated associates' offices. I also authorize said persons to contact me and listed parents/guardians via call, text, mail, and listed school information. I authorize DPH to text my numbers listed and accept the risks for receiving texts from DPH. I understand that DPH is not responsible for any potential costs of texts.

* I understand that Teledentistry interactions are not equivalent to an in-person clinical examination and that the dentist shall not be physically present during some services. It is my responsibility to have my child seen in person at least annually, recommended by our dentists.

* I authorize and approve the release & disclosure of my child's medical/dental records maintained by the Southeast Health District, affiliated associates, contracted persons, and other healthcare/dental providers, as requested by a healthcare/dental provider or the parent/guardian.

* I will contact the Southeast Health District Teledentistry staff with any changes that may occur to the medical/dental history or record while participating in the program or if I want to recind consent or request copies at 912-287-4893.

* I am aware of and understand the Ware County Board of Health notice of privacy practices and can view it at https://www.sehdph.org/services/teledentistry. My signature signifies that this agreement is valid for one year from the date signed and/or until treatment is rendered complete by the dentist.

* I have read & agree to the terms above & have provided true and accurate information concerning the patient and myself to the best of my knowledge on all forms. I affirm I am a legal parent or legal guardian to the patient.

CHILD/PATIENT NAME: (PRINT) _____

PARENT/GUARDIAN NAME: (PRINT) _____

PARENT/GUARDIAN: (SIGNATURE) _____

TODAY'S DATE: _____/_____/_____

Appling	Bulloch	Coffee	Tattnall
Atkinson	Candler	Evans	Toombs
Bacon	Charlton	Jeff Davis	Ware
Brantley	Clinch	Pierce	Wayne

PARENT QUESTIONNAIRE – TELEDENTISTRY 2026-2027

PLEASE COMPLETE ALL OF THE QUESTIONS BELOW TO THE BEST OF YOUR KNOWLEDGE. THIS INFORMATION ALLOWS US TO COLLECT DATA CONCERNING ORAL HEALTH KNOWLEDGE AND TO TRACK CURRENT BARRIERS FAMILIES FACE WHEN SEEKING DENTAL TREATMENT IN RURAL AREAS. THANK YOU FOR YOUR PARTICIPATION.

1. How would you rate the health of your child's teeth/mouth?

□ Excellent □ Good □ Fair □ Poor

2. How often has your child complained of dental pain/problems/swelling in the past year?

□ Never □ Sometimes □ Often

3. Approximately how long ago did your child visit a dentist?

□ Never □ 6 months ago or less □ 6 mo-1 year ago □ 1-2 yrs ago □ more than 2 yrs ago

4. Why did your child last visit a dentist?

□ Cleaning/checkup □ Dental pain/problem □ Treatment of a previously diagnosed problem
□ Never □ Other, explain: _____.

5. If your child needed dental treatment and did NOT receive it, what is the primary reason? (please choose one answer best suited to your case)

□ Financial issue □ Transportation issue □ Fear/Anxiety □ Cannot take off work/school
□ Cannot find a dental provider that accepts my insurance □ Forgot about appointment
□ Other, explain: _____.

6. Have you had trouble locating a dentist that accepts your child's insurance?

□ Never □ Sometimes □ Often

7. How often does your child brush their teeth?

□ 1x morning only □ 1x night only □ 2x (once morning and once night) □ More than 2x day

8. How often do you supervise/assist your child when brushing their teeth?

□ Never □ Sometimes □ Often

9. How many times a day does your child consume sugary/acidic snacks or drinks BETWEEN meals? (ex. Candy, chips, juice, sweet tea, sports/energy drinks when not eating meals)

□ Never □ 1x day □ 2x day □ 3x or more day

10. How often does your child use a fluoride rinse, tablet, or drop at home other than in toothpaste?

□ Never □ Sometimes □ Often

11. Which county does your child attend school in?

□ Brantley □ Charlton □ Clinch

12. Do you have any recommendations or suggestions for improvement concerning our program?

_____.