



Your School's On-site Comprehensive Dental Care Provider

**A NEW FORM MUST BE COMPLETED
EACH SCHOOL YEAR!**

Please fill form out **COMPLETELY** to ensure your child is able to be seen!

**DO YOU HAVE A
CURRENT DENTIST? Y N** ←

If your child has a current dentist of record, you may wish to continue treatment with that provider. If you do **not** want to switch your child to be seen by our dentist at school **DO NOT** complete this form.

General and Health Information

Child's Legal Name: (first) _____ (M.I.) _____ (last) _____
 School: _____ County: _____ (circle) M F
 Child's Birthdate: ____/____/____ Age: ____ Grade: ____ (circle) AM PM
 Address: _____ City: _____ State: ____ Zip Code: _____
 Phone: () _____ Email: _____

Your child's Social Security number: _____ - _____ - _____

Child Dental Information

(Please complete this form to the best of your knowledge)

Is child in pain? No Yes How long? _____

Please indicate any of the following problems:

- | | | |
|--|---|--|
| <input type="checkbox"/> Discomfort, Clicking, or Popping In Jaw | <input type="checkbox"/> Lost/broken Filling(S) | <input type="checkbox"/> Stained Teeth |
| <input type="checkbox"/> Red, Swollen, or Bleeding Gums | <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Locking Jaw |
| <input type="checkbox"/> Sensitive Tooth, Teeth, or Gums | <input type="checkbox"/> Ringing In Ears | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Blisters/sores In or Around the Mouth | <input type="checkbox"/> Broken/chipped Tooth | <input type="checkbox"/> Loose Tooth |
| <input type="checkbox"/> Other(s): _____ | | |

Does child require pre-medication? Yes No Don't Know

Previous Dentist: _____ Phone # (____) _____

Last Dental Exam ____/____/____ Last Dental X-Ray ____/____/____

Times a day child brushes? _____ Times a week child flosses? _____

Child Medical History

Is child taking any of the following medications

- Pain Killers (Including Aspirin) Ritalin Stimulants Blood Thinners Tranquilizers Insulin Muscle Relaxers
 Other(s): _____

Child's Physician (Doctor's Name or Clinic Name) _____ Phone # (____) _____

Address _____

City _____ State _____ Zip _____

Pharmacy Phone # (____) _____ Child's Weight _____

Does this child have or have ever had any of the following diseases, medical conditions or procedures?

- | | | |
|------------------------------|---------------------------------|-------------------------------------|
| Y N Heart Murmur | Y N Tonselitis | Y N High/Low Blood Pressure |
| Y N Rheumatic Fever | Y N Respiratory Problems | Y N Hepatitis |
| Y N Artificial Heart Valve | Y N Asthma/Difficulty Breathing | Y N Artifical Bones/Joints/Implants |
| Y N Congenital Heart Disease | Y N Blood Transfusion(s) | Y N Liver/Kidney/Organ Problems |
| Y N Scarlet Fever | Y N Leukemia/Anemia | Y N HIV+/AIDS/ARC |
| Y N Surgeries/Operations | Y N Diabetes/Hypoglycemia | Y N Tuberculosis TB |
| Y N Cancer/Tumors | Y N Hemophilia | Y N Psychiatric Problems |
| Y N Chemotherapy | Y N Abnormal Bleeding | Y N Hyperactive/ADD |
| Y N Jaw Problems TMJ/TMD | Y N Cleft Lip/Palate | Y N Fainting/Seizures/Epilepsy |
| Y N Heart Problems | Y N Birth Defects | Y N Cerebral Palsy |

Please list any other medical condition(s) child has or ever had _____

Is child allergic to: Latex Penicillin/Amoxicillin Tetracycline Dental Anesthetics (Novocaine) Aspirin Food Allergies
 Other(s): _____

PLEASE COMPLETE ENTIRE FORM, FRONT AND BACK

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Payment Information: Must be filled out for child to be seen

Medicaid
Private Insurance
Self Pay: \$99

Medicaid/Hoosier Healthwise Information:

Child's 12-digit Medicaid Recipient ID Number:

Private Insurance Information: Please complete entire section and include copy of DENTAL Insurance Card.

Name of Private **DENTAL** Insurance Company: _____ Ins. Phone: _____
 Group Number: _____ Employer Name: _____ Co. Phone: _____
 Name of person under whom child is covered: _____ BIRTH DATE of Insured Adult: ___/___/___
 Social Security # of insured adult: _____ Contract/ID #: _____

Secondary Insurance: Insurance Name: _____ Policy Holder: _____ Date of Birth: ___/___/___
 ID #: _____ Employer Phone: _____ Ins. Phone: _____

Financial Statement: Please be aware that any treatment that is rendered may affect future benefits that your child will receive under: private insurance, health insurance program, Medicaid, and Hoosier Healthwise.

Self-Pay Option/Financial Assistance Information

I wish to pay out of pocket for my child to receive a dental exam, x-rays, cleaning, and fluoride. Fee \$99. For a complete list of our fees, please visit our website: www.schoolsmiles.com

Payment Method: (circle) **Cash** **Check** **Debit/Credit**

Please make checks and money orders payable to: School Smiles

Grant Funds available on first come first serve basis (please check if interested in applying)

Important: Parent/Guardian Signature Required

If you wish to have your child participate in this program, please sign and complete BOTH sides of this form. If you have any questions regarding your child's dental health, you may contact us directly at 1.855.49SMILE, or please feel free to visit our website at: www.schoolsmiles.com for further information and frequently asked questions. By signing below you are consenting to (exam, x-rays, cleaning, fluoride and sealants, as needed) for routine and 6 month check-ups.

I _____ "Parent/Guardian" give permission for my child to receive dental treatment from the _____
 (Parent/Gaurdian Printed Name)
 School Smiles dental providers at their school during school hours.

_____ Date _____ Child's Age _____
 Parent/Legal Guardian Signature

Parent/Guardian Signature for Treatment (Fillings)

I _____ (Parent/Guardian Printed Name) give permission for _____ (Child's Printed Name) to receive dental treatment (in the form of restorative fillings and local anesthetic to numb the area) from the School Smiles dental provider at their school. I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the initial examination (in this circumstance: larger fillings)

BY SIGNING BELOW, I GIVE PERMISSION TO THE DENTIST TO MAKE ANY/ALL CHANGES AND ADDITIONS AS NECESSARY ON MY CHILD IN REGARDS TO RESTORATIVE FILLINGS, AS STATED ABOVE.

_____ Date _____
 Parent/Legal Guardian Signature

***Please note: Shall your child need treatment beyond fillings, such as stainless steel crowns, pulpotomies or extractions, additional consent WILL be obtained. If your child requires treatment outside of what can be provided by School Smiles, a referral will be provided for you.*

HIPAA Acknowledgement

Privacy of your child's protected health information remains extremely important, and we are committed to ensure your privacy.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my child's health care information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

_____ Date _____
 Parent/Legal Guardian Printed Name Parent/Legal Guardian Signature

PLEASE COMPLETE FRONT AND BACK OF FORM AND RETURN TO YOUR CHILD'S TEACHER

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