PLEASE COMPLETE ENTIRE FORM, FRONT AND BACK

SchoolSmiles
On-site Dental Care

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:

❑ Discomfort, Clicking, or Popping In Jaw	❑ Lost/broken Filling(S)	❑ Stained Teeth
❑ Red, Swollen, or Bleediing Gums	❑ Teeth Grinding	❑ Locking Jaw
❑ Sensitive Tooth, Teeth, or Gums	❑ Ringing In Ears	❑ Bad Breath
❑ Blisters/sores In or Around the Mouth	❑ Broken/chipped Tooth	❑ Loose Tooth

❑ 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 Asprin) ❑ 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 Congential 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) ❑ Asprin ❑ Food Allergies

❑ Other(s): _____

PLEASE COMPLETE ENTIRE FORM, FRONT AND BACK

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

Medicaid ☐ **Private Insurance** ☐ **Self Pay: $99** ☐

Managed Care Plan: **Passport** ☐ **Aetna** ☐ **Wellcare** ☐ **Humana/Caresource** ☐

Child's 10-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 number of insured adult: _____ Contract/ID number: _____

Secondary Insurance information Insurance Name: _____ Policy Holder: _____ Date of Birth: _____

ID Number: _____ Employer Phone: _____ Insurance Co. Phone #: _____

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

Self-Pay Option/Payment Information

I wish to pay out of pocket for my child to recieve a dental exam, x-rays, cleaning, and fluoride. ***Fee $99.*** *This fee must be paid up front in order to receive dental services; a member from the home office will contact you to review your options.*

Grant Funds available on first come first serve basis. Please check if interested. ☐ We will contact the School to get a nomination form and you will be contacted if your child does not qualify. Your child will not be seen if they do not qualify and you do not wish to pay the self-pay option.

For a complete list of our fees, please visit our website: www.schoolsmiles.com

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 _____ to receive dental treatment from the
(Parent/Gaurdian Printed Name) (Child's Printed Name)

School Smiles dental providers at their school during school hours.

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

Parent/Guardian Signature for Treatment (Fillings)

I _____(Parent/Guardian Printed Name) give permission for my child to recieve dental treatment (in the form of restorative fillings and local anesthestic 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 SIGINING 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.

_____ _____
Parent/Legal Guardian Signature *Date*

***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.

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

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

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