

Smiles on Wheels Mobile Dental Hygiene Program

Parent/Guardian Consent and Health History

Give your child a SMILE and prevent cavities!

Please return this form to your child's teacher tomorrow!

Thank you!!

Yes, I want my child to have:

- A Dental screening, Dental Cleaning and Fluoride treatment by a licensed dental hygienist
 1. I understand that this program is intended for children who do not have a dental home and otherwise would not be able to receive treatment.
 2. The program will bill my insurance or Medicaid if I have that benefit and that I will be required to provide my insurance information to receive the service. If I do have insurance the program will waive my co-pay. If I do not have insurance I understand that the fee for this service is \$37.00 payable to Smiles on Wheels. *Please attach payment to consent form.*
 3. If you need assistance with the cost of this program please contact your school nurse or Smiles on Wheels @ 517-740-5620.

Required Signature of Parent/Guardian _____ Date ___/___/___

Printed name of parent/guardian _____ Relationship to Child _____

No, I do not want my child to receive decay preventing dental services. Please return form to school even if you say no. Child's Name _____

If you say yes, to receive dental services, please complete the remainder of this form: PRINT CLEARLY IN INK

Your child's personal information will be kept confidential and will not be shared with any person who is not directly involved in the care of your child as part of the Health Insurance Portability and Accountability (HIPAA). It is understood that if false information is given, that this may disqualify my child from receiving treatment.

Child's Legal Name _____ Gender: Male Female Child's Date of Birth ___/___/___
First Middle Last Month/Day/Year

Child's Address: _____ City _____ State _____ Zip Code: _____

Parent/Guardian Phone ___-___-___ Cell Phone ___-___-___ E-mail Address _____

In an Emergency Contact _____ Emergency Phone # _____

Child's Social Security # ___-___-___ Parent's Social Security Number ___-___-___

Child's 10 Digit Medicaid, Healthy Kids Dental/MI Child ID # _____

Name of Insured Adult Under Whom Child is Covered: _____ Insurance Group Number (if known) _____

Place of Employment _____ Birth date of Insured Adult ___/___/___

Check dental insurance that you have: Medicaid Healthy Kids Dental MI Child
 Delta Dental Blue Cross Other Insurance (Give name _____)

Does your child participate in Free and Reduced School Lunch Program? Yes No

Child's Ethnic/Racial Background: (Check all that apply): White Black/African American Asian Hispanic
 American Indian/Alaska Native Native Hawaiian/Pacific Islander Other

Child's Health History:

Has your child visited a dentist in the past six months? Yes No If yes, dentist's name _____

My child's dental visits have been a good experience? Yes No

Is your child taking any medication? Yes No If yes, name of medication _____

Does your child have allergies (such as latex or food)? Yes No If yes, what is child allergic to? _____

Is child under the care of a physician? Yes No If yes, explain _____

Does your child have learning or emotional impairment? Yes No

Please check any conditions that your child has: TB Asthma Seizures/Convulsions Hepatitis Diabetes Rheumatic Heart Disease HIV Aids Hearing Artificial Joints

Has your child had any serious health conditions not mentioned above? Yes No

If yes, please explain _____ Physician's Name _____