Smiles on Wheels Parent Consent Form

Dental Sealant & Fluoride Varnish Program

About Your Child

School: _____ Grade: _____ Teacher: _____

Child's Legal Name: _____ (First) _____ (Middle) _____ (Last)

Address: _____ (Street) _____ (City) _____ (ZIP) Phone #: _____

Date of Birth: ____ (Month) / ____ (Day) / ____ (Year) Age: ____ M or F (Circle One) Parent Email: _____

Preferred Language (Check one): ☐ English ☐ Spanish ☐ Other (Please Specify): _____

Which of the following describes your child (Check One or More): ☐ Black/African American ☐ White ☐ Hispanic/Latino ☐ Asian ☐ Arab American ☐ American Indian/Alaskan ☐ Native Hawaiian/Other Pacific Islander ☐ Other

Parent Consent

Tooth decay is one of the most common diseases found in children. Fluoride varnish can be painted on teeth to protect teeth from cavities. Fluoride varnish can be applied up to four times a year.

☐ YES, I give my permission for my child to receive: Fluoride varnish, oral screening, dental cleaning and sealants, if needed.
☐ YES, I give my permission for my child to receive: Oral screening and sealants only.
☐ NO, I do not give my permission for my child to receive treatment with Smiles on Wheels.

Printed Parent Name: _____ Date: _____

Signed Parent Name: _____

This consent will be valid for the 12-month period of this program.

EVENT INFORMATION

Event Site: _____

Event Date(s): _____

Health History

(Please circle):

YES/NO 1) Is your child allergic to anything? *If yes, what?* _____

YES/NO 2) Is your child taking any medications? *If yes, what?* _____

YES/NO 3) Does your child have any medical conditions such as heart disease, asthma, hay fever, hepatitis, cancer, diabetes, or any other medical conditions? *If yes, what?* _____

YES/NO 4) Does your child have learning or emotional impairments? *If yes, what?* _____

5) When was your child's last dental visit? _____

Insurance Information

No payment is required from you for this program. However, Medicaid/Healthy Kids Dental/MIChild and other dental insurance carriers will be billed to help cover the cost of this program. Please fill out insurance information.

Medicaid #: _____ Name of Insurance: _____

Insured Name: _____ (First) _____ (Last)

Date of Birth: ____ (Month) / ____ (Day) / ____ (Year) Group #: _____

Policy or ID #: _____ *OR* Insured SS #: ____ - ____ - ____

Employer: _____ Employer Phone #: _____

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 Act (HIPAA).

Dental services may be obtained at the patient's dental home rather than with the mobile dental facility and obtaining duplicate services may affect insurance benefits that he or she receives from private insurance, a state or federal program, or other third-party provider of dental benefits.

FOR OFFICE USE ONLY

Date: _____ RDH: _____ AD/CH Prophy: _____ Varnish: _____ Screen: _____ # Teeth: _____ Fills: _____ Cavities: _____

SP Needs: _____ Urgent Care/Abscessed #: _____ SEAL #: NONE 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29

Notes: _____

Date: _____ RDH: _____ AD/CH Prophy: _____ Varnish: _____ Screen: _____ # Teeth: _____ Fills: _____ Cavities: _____

SP Needs: _____ Urgent Care/Abscessed #: _____ SEAL #: NONE 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29

Notes: _____

Sealant Retention Check:

Date: _____ RDH: _____ All Retained: _____ REPLACED #: 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29

002