Smiles To Go, LLC

DENTAL SCREENING CONSENT FORM

1620 East Main Street Liberty, MS 39645

Office: 601-980-5015 or 601-657-5941 Fax: 601-657-5599

School:_____Grade:_____ Teacher:_____

Smiles To Go, LLC will visit your child's school to provide select dental services (exams, sealants, x-rays, fluoride, cleaning, etc.). Dentists, Registered Dental Hygienists, or trained staff will provide these services in your child's school with portable equipment. This consent form will be effective for the whole school year and will allow our team to provide a six month checkup. **PLEASE COMPLETE ALL OF THE INFORMATION REQUESTED BELOW SIGN THE SIGNATURE LINE AND RETURN TO THE SCHOOL** if you would like your child to receive this service. You will receive a report after your child is seen. If you have questions, please call (601) 980-5015 or (601) 657-5941.

PLEASE PRINT AND USE INK

Child's Name_____ Male_____ Female____ Ethnicity_____

Birthdate: _____ Phone: _____ Preferred Language _____

Address_____**City**_____**ZIP**_____ **Race** _____

Child's Social Security Number Phone Number(s):

Medicaid enrolled: _____YES _____NO Medicaid Number:_____

CHIP Enrolled: _____YES _____NO CHIP Number:_____

Other Insurance: _____Yes _____ No If yes, name of Insurance:_____

Policy Number:_____ Name of Subscriber: _____

Employer: _____ Subscriber's Date of Birth _____

Subscriber's Social Security Number _____

Health History

Has your child ever had any serious health problems listed below: (Please check)

____Diabetes____Asthma____Behavior Problems _____Mental Retardation _____Anemia_____Sickle Cell

____ Other (explain)_____

What is your child's current weight ____Height _____

If older than 13 years old does your child smoke? ____yes____no

Is your child allergic to any food or medication? If so please list_____

If your child is currently taking any medication please list in the blank provided Is your _____ child allergic to? (please check) ____latex ____acrylic/plastic.

If your child is currently seeing a dentist list their name_____Date of last dental visit_____

PARENT OR LEGAL GUARDIAN MUST READ AND SIGN BEFORE CHILD MAY PARTICIPATE

I give permission for Smiles To Go, LLC to treat my child. This information form will become part of our permanent record and will be held in strict confidence. I verify that I have read this form and understand the privacy of health information (HIPPA). I give permission for the Clinic to provide quality assurance audits of dental records. It is important to note, if the patient already has a dentist, then contact them to arrange dental care through that provider. Treatment provided may affect the future benefits that the patient receives under private insurance, Medicaid; or the Children's Health Insurance Program (CHIP). For example, if you choose to participate in our program then this will count as one of your regular dental visits, etc- All children are eligible to receive these services regardless of whether they have insurance or not.

Signature: X_____

Please Print Name:_____**Date:**_____