IN-SCHOOL DENTAL CARE

Medicaid & Healthy Start/Healthy Families cover 100% of treatment

Please complete, sign & return to school. **Questions? Please call (888) 833-8441**

Taking care of your child's teeth is important to keep them healthy.

1 TELL US ABOUT YOUR CHILD

IF YOUR CHILD ALREADY HAS A DENTIST, YOU SHOULD CONTINUE SERVICES WITH THAT PROVIDER.

School or Program Name ______________________ County ____________

Child's Teacher ______________________ Room # ______ Grade ______ AM/PM

Parent/Guardian Name (signing below) ______________________ Relationship to child (check one) ☐ Custodial parent ☐ Legal guardian

Address ______________________ City/Zip ____________

Email ______________ Phone ( ) ____________ Alt. Phone ( ) ____________

Child's Legal Name ______________________ Child's Date of Birth ____________ Male / Female (circle one)

Child's Social Security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

2 INSURANCE INFORMATION

Medicaid & Healthy Start/Healthy Families cover 100% of treatment

☐ CHILD HAS MEDICAID/HEALTHY START/HEALTHY FAMILIES

Circle one of the following: Medicaid, Amerigroup, CareSource, Gateway, United Healthcare, Buckeye, Molina, Unison, Wellcare, Other: ____________

Enter Child's Recipient ID Number HERE: → ______________________

☐ CHILD HAS PRIVATE DENTAL INSURANCE

Ins. Company name (other than Medicaid) ______________________ Ins. Phone ____________

Group # ____________ Employer name ____________ Co. phone ____________

Name of Insured Adult ______________________ **BIRTH DATE of Insured Adult** ____________

Policy # ____________ Social Security # of insured adult ____________

FOLD

☐ CHILD IS UNINSURED **If paying for services, please make check or money order payable to Smile Care, LLC & staple to this form.**

☐ I am able to pay the full fee for a dental cleaning, screening & fluoride per visit. Ages 13 or younger: **$70.00** Ages 14 or older: **$80.00**

☐ I certify that I need to pay for a subsidized service because I am unable to pay the full fee. It will cover dental cleaning, screening & fluoride per visit. Ages 13 or younger: **$43.00** Ages 14 or older: **$54.00**

☐ I certify that I am unable to pay the full or subsidized fee and request full financial assistance, which will cover dental cleaning, screening & fluoride (charity care unavailable for restorative treatment). We will send you a charity care application. Charity care available only once per school year.

3 CHILD'S MEDICAL HISTORY

CHECK EACH CONDITION THAT APPLIES TO YOUR CHILD

- ☐ Recent Dental Problems
- ☐ Latex Allergy
- ☐ Allergy to Medications/Other
- ☐ Asthma or Wheezing
- ☐ Behavioral Problems
- ☐ Heart Problems/Murmur
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Hemophilia/Bleeding Problems
- ☐ Sickle Cell Anemia
- ☐ Anemia/Fainting
- ☐ Epilepsy/Seizures
- ☐ Liver Problems/Hepatitis
- ☐ Kidney Problems
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Communicable Diseases

Notify us of any medical history changes. A thorough and complete medical and dental history are important for a proper dental examination and evaluation.

List allergies ______________________

Name/phone # of child's physician ______________________

Use space below to provide additional details on your child's health, including current medical treatment, other significant past illnesses, alcohol & tobacco use (including smokeless). List current medications. Attach another page as needed.

____

☐ **CHECK IF ANTIBIOTIC PRE-MEDICATION REQUIRED**

Approx. date of last dental visit. ____________

4 READ AND SIGN BELOW

I request that the dentist perform dental care on my child. I have read the IMPORTANT NOTICE AND CONSENT and understand and agree to these terms.

SIGN HERE ______________________ ____________ Date

Print Name ______________________

OFFICE USE ONLY		
IOE	6 mo	
		exam, prophy, fluoride
		exam, prophy
		(4)bwx or (2)bwx
		PA films for diagnosis
		seal perm molars
		csf

For your privacy, please fold & secure.

ESPAÑOL AL REVERSO

Visit us at: mobiledentists.com **Phone:1-888-833-8441 Fax:1-888-330-4331**

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