

Help A Child Smile Mobile Dental Program Great News! The Help a Child Smile dental program has partnered with your child's school to offer full-service dental care at the school.



Dental care is very important for your student's health.

ESPAÑOL AL REVERSO

Easy & Convenient... Has your child visited another dentist within the last 12 months? If not, they can enroll. **IF YOUR CHILD ALREADY HAS A DENTIST YOU SHOULD KEEP GOING TO THAT DENTIST.**

TOTAL DENTAL CARE	Our complete dental care includes an exam, x-rays, cleaning, fluoride, sealants, and cavity treatment when needed.
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School: _____ County: _____
 Student Name: _____ M F Student Date of Birth ____/____/____
 Primary Phone: (____) _____ Day Phone: (____) _____ Cell Phone: (____) _____
 Address: _____ Apt#: _____ City: _____ Zip: _____
 Email: _____ Grade: _____ Teacher's Name: _____

CHILD HAS MEDICAID/PEACHCARE:

Enter Child's 12 digit Medicaid Recipient ID Number HERE →

Medicaid & Peachcare cover 100% of treatment

CHILD HAS PRIVATE INSURANCE: Insurance Co. Name: _____ Phone # of Co.: _____
 Policy Holder's Name: _____ Policy Holder's DOB: _____
 Policy Holder's ID or SS # _____ Employer: _____

CHILD IS UNINSURED: (Circle One) Check, Credit Card or Cash

CHILD'S MEDICAL HISTORY

CHECK EACH CONDITION THAT APPLIES TO YOUR CHILD

- | | | |
|---|---|---|
| <input type="checkbox"/> Recent Dental Problems | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Communicable Disease |
| <input type="checkbox"/> Allergy to Medications/Other | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Wheel Chair Access |
| <input type="checkbox"/> Asthma or Wheezing | <input type="checkbox"/> Liver Problems/Hepatitis | <input type="checkbox"/> Heart Condition (describe below) _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney Problems | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | _____ |
| <input type="checkbox"/> Hemophilia/Bleeding Problems | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Tuberculosis | _____ |

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

List allergies to medication/other: _____
 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 and premedication if needed for dental treatment.

READ AND SIGN BELOW

I understand and authorize Mark Shurett, DDS, PC (Provider) and its affiliated dentists to provide the following services for the above-named child for whom **I am the custodial parent or legal guardian**: dental exam & oral hygiene instruction, teeth cleaning, fluoride treatment, x-rays & dental sealants. I authorize the dentist to fill any cavities or to place a stainless steel crown over the tooth if needed. I authorize Provider to extract any problem baby teeth or provide a baby root canal (removal of the nerves inside the tooth) as needed. I understand that there are risks to dental treatment including swelling or pain that may occur from the injection of a local anesthetic or allergic reaction. (For additional information regarding the risks of treatment and treatment alternatives, please call the number below.) I authorize & direct Provider to bill & collect payment from any Medicaid, insurance, or other payer. If I have private dental insurance, I will be billed for & agree to pay any deductibles and/or co-pays. Unless I have made pre-arrangements to attend, and am there at the time of service, services will be provided without my presence. I have received the Notice of Privacy Practices attached to this form and consent to the release of my child's medical record information as described therein.

You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the land-line and/or mobile telephone numbers provided on this consent form.

This signed consent authorizes my child's initial dental visit and follow-up visits. I may withdraw this consent at any time in writing to the address below.

SIGN HERE _____ **PRINT NAME** _____ **DATE** _____ **For your privacy, please fold & secure.**

Healthy Smiles Happen at School



Great News! Help a Child Smile dental program is joining with your child's school to offer full-service dental care at the school.

The American Dental Association recommends yearly checkups for children. If your child has not seen a dentist in the last 12 months, this program is for you!

Already enrolled? Please fill out the new form, so we can update your records.

No Cost to You

If your child is insured with Medicaid / PeachCare for Kids®, there is no cost to you. We also accept most private dental plans.

Easy & Convenient

When your child visits an in-school dentist, you save time. Local, licensed dentists and hygienists provide the best of care from our fully equipped mobile offices. Dental care at school includes a complete exam, x-rays, cleaning, fluoride, sealants and cavity treatment when needed.

Keep Your Child Healthy

If your child does not see a dentist regularly, he or she is at risk for:

- Early Tooth Loss caused by dental decay
- Gum and Heart Disease
- Speech Problems

Childhood cavities are more common than asthma. Infection from tooth decay can lead to other health problems, as well as problems eating, speaking, and learning.

Simply fill out the enrollment form. Return it to your school TODAY.

If you have questions, please feel free to call us toll-free at (800) 770-0388,

