

Smiles To Go, LLC. 1620 East Main Street Liberty, MS 39645 Office Phone: 601-657-1164

Fax: 601-657-5936

Dear Parents:

Your School District has partnered with Smiles To Go to visit your schools. With parental permission, Smiles To Go offers preventive services to ALL students regardless of dental coverage. Dental Decay is the #1 chronic disease among school age children. Research literature has shown that school based dental sealant programs have had a major impact in decreasing the amount of dental decay among children. With this in mind, here are a few facts from Smiles To Go:

- Preventive services are offered to ALL students regardless of any dental coverage.
- We treat Head Starts, Pre-K through twelfth grade students, whose parents have consented.
- > Urgent cases will be referred immediately to a LOCAL dentist.
- > The MS Dental Board of Examiners does permit billing to insurances, however, no out of pocket charges go to the student or family.
- Tooth brushes are given to every student who participates.
- All the team's equipment is portable for easy setup and take down.

Thank you again for your participation and help in implementing this program. Please contact me at (ashley@smiles2go.net) for any additional information.

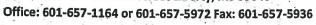
Sincerely,

Ashley Casey Owner

Smiles To Go, LLC

DENTAL SCREENING CONSENT FORM

1620 East Main Street Liberty, MS 39645



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School:	X 5 1 1	Grade:_		eng av 8	3 1 2 2	Teacher:		
Smiles To Go, LLC will v	isit your child's	school to p	rovide select d	ental service	es (exams, s	sealants, x-rays,	fluoride, cleani	ng, etc.).
Dentists, Registered Der	ital Hygienists,	or trained s	taff will provide	these serv	ices in your	child's school w	th portable eq	lipment.
This consent form will b	e effective for	the whole	school year an	wolle lliw b	our team t	o provide a six r	nonth checkup	PLEASE
COMPLETE ALL OF THE	INFORMATIO	N REQUESTI	ED BELOW SIG	N THE SIGN	ATLIDE LIN	E AND DETLIEN	TO THE SCHOOL	I if you
would like your child to	receive this se	rvice You v	vill receive a re	port after v	our child le	seen If you have	e questions of	ease call
(601) 657-1164.			viii receive a (e	port arter y	our crint is	seem it you nav	e questions, pi	cuse cuii
		DIFACE DE		2 v - 14	100 100 10	- "V" (")		100
Child's Name	* 1	PLEASE PH	INT AND USE I	NK .	".	.00C #8 30	9 11	U _{acc}
				- 22	Male	Female_	Ethnicity	
Birthdate:	Phone:			Phone:_		3 4 -		
Address:			City	e==:. :::	State	Zip		
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Child's Social Security N	umber:	,00 access	11 0 0 v	a		n partir		y a
	YES	NO Me	dicald Number		* · ·	(9)		<u> </u>
	YESNC	the foreign of the party and their		230	F#: W.J.J.		Constant San Francisco	
Other Insurance:	Yes No	o If yes, nam	e of Insurance		1,75		50 m - 100 m 100 m 200 m	2.
Policy Number:	and the second		I - B - B - B - B - B - B - B - B - B -	ame of Subs	criber:			
Employer:				per's Date o				18 P
Subscriber's Social Secur	lty Number	1 31 19 1						
Subscriber & Social Secur	ty Number	13	35 1 9	 ,		da "	500 Es	viti 1530
Health History		Turk I ye	38 8 3	48 E, 8	N	8	n Mil e,	
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Has your child ever had a	iny serious nea	ith problem	ns listed below:	(Please che	eck)	vi viencega I		1 1
DlabetesAsthr	naBehavi	or Problems	Mental	Retardation	Aner	niaSickle (Cell	a (* * *
— Other (explain)	7 13 1							
What is your child's curre	ant weight	_Height		off ee	e			
If older than 13 years old	l does your chi	ld smoke?	yes	no		10 10	2.1	
Is your child allergic to a	ny food or me	dication? If	so please list					11 14
if your child is currently t	taking any med	lication plea	se list in the bi	ank provide	d is your			
child allergic to? (please	check)lat	exacry	lic/plastic.	100° (I		* Horse	10 II II	
		4 1 7 <i>9</i> 3 1 1			10.00			- E
If you'r child is surrough			·	2 N		v E st		47
If your child is currentl	y seeing a de	intist list th	eir name			_Date of last d	entai visit	-
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PARENT OR LEGAL GUAR	IDIAN MUST R	FAD AND S	IGN REFORE CL	III D MAY D	ADTICIDATI			
			IGIN DEFORE CI	ILD WAT P	ARTICIPATI	. 18		
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I give permission for S	miles To Go,	LLC to tre	at my child. T	his inform	ation form	n will become p	part of our pe	rmanent
record and will be hel	d in strict co	nfidence. I	verify that I h	nave read t	this form a	and understand	the privacy	of health
information (HIPPA).	l give permi	ssion for t	he Clinic to	rovide au	ality accu	rance audits o	f dental reco	ords. It is
important to note, if	the nations	already ha	s a dontiet	then cente	et them	e orrango dos	tal care thro	ugh that
provider Treatment	the patient	an Cauy He	is a deficist,	men conta	ict them	o arrange dei	ital cale till	ugii tilat
provider. Treatment	provided ma	y arrect th	e future ben	efits that	the patier	nt receives un	der private if	isurance,
Medicaid; or the Chil	gren's Healt	h Insuranc	e Program (CHIP). For	example,	if you choose	to participa	te in our
program then this will	count as one	of your re	gular dental v	isits, etc-	All childrer	are eligible to	receive these	eservices
regardless of whether	they have in	surance or	not.	, •	il.		9.1	'C."
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Signature: X		·		88				8
Please Print Name:	395		Date:				.0048	· ·