PARENT CONSENT FORM
Dental Fluoride Varnish Program

SMILES ON WHEELS
122 Highland Dr., Jackson MI 49201
517-740-7422 Fax: 517-315-4918 Upper Peninsula 906-221-2389 smilesonwheels@hotmail.com

_____ _____ _____ _____
Child's First Name **Child's Middle Name** **Child's Last Name (Legal)** **Age**

Address_____City_____Zip_____

Phone #_____Cell Phone #_____

Date of Birth: Month/Day/Year _____/_____/_____ M____ F_____ Preferred language: English ___Spanish ___Other__

Which of the following describes your child? (Check one or more)
____ Black/African American ____ White ____ Hispanic/Latino ____ Asian ____ Other
____ American Indian/ Alaskan ____ Native Hawaiian or Pac. Islander ____ Arab American

HEALTH HISTORY:
1. Is your child allergic to anything? ☐ YES ☐ NO If yes, what? _____
2. Is your child taking any medications? ☐ YES ☐ NO If yes, what? _____
3. Does your child have any medical conditions such as heart disease, asthma, hay fever, hepatitis, cancer, or diabetes, etc.? Or any other medical condition? ☐ YES ☐ NO If yes, what? _____
4. Does your child have learning or emotional impairments? ☐ YES ☐ NO _____

No payment is required from you for this program. **However, Medicaid/Healthy Kids Dental/MI Child and other dental insurance carriers must be billed to cover the cost of this program. Please fill out insurance information.**
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 (HIPAA).*

Name of Insurance: _____ Policy/Medicaid/ID#: _____

Insured Parent Name: _____Parent-- Date of Birth: _____-_____-_____

Group#: _____ Insured SSN#: _____-_____-_____

Insured Employer: _____ Phone #: _____

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.

_____**YES, I give my permission** for my child to receive**:**
Fluoride Varnish, Oral Screening and Toothbrush Dental Cleaning.

Event Site: _____

_____**NO, I do not give my permission** for my child to receive dental treatment.

Event Date: _____

_____ _____
Printed Parent Name **Signature of Parent or Guardian**
Parent or Guardian Email address_____
Smiles on Wheels has my permission to use photos of my child for educational or promotional purposes. ☐ Yes ☐ No
This consent will be valid for the 12-month period of this program.

Date_____ RDH_____TB CH Prophy_____Varnish_____Screen _____# teeth ____ Fills___ Cavities_____
Urgent/Abscessed #_____ White spots_____ SP Needs yes/no_____ Referral letter given yes/no____

Notes: _____