SMILES ON WHEELS

Dental Fluoride Varnish Program

PARENT CONSENT FORM

122 Highland Dr., Jackson MI 49201
517-740-7422 Fax: 517-315-4918 Upper Peninsula 906-282-8741 info@smilesonwheels.org

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** _____
5. **When was your child's last dental cleaning appointment or fluoride varnish treatment?** _____

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. *Smiles on Wheels follows CDC recommendations for proper Infection Control to prevent the spread of COVID-19 and all other communicable diseases.*

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

Event Site: _____

Event Date: _____

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

_____ _____
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.

1st Visit

Date_____RDH_____TB CH Prophy_____Varnish_____Assessment_____# Teeth_____Fills_____Concerns_____
Urgent/Possible Infection #_____White spots_____SP Needs yes/no_____Referral letter given _____
Temp: Pulse Ox:
NOTES: _____

2nd Visit

Date_____RDH_____TB CH Prophy_____Varnish_____Assessment_____# Teeth_____Fills_____Concerns_____
Urgent/Possible Infection #_____White spots _____ SP Needs yes/no__Referral letter given _____
Temp: Pulse Ox:
NOTES: _____

Revised 08/2020