Smiles on Wheels
ACCESS TO DENTAL HYGIENE CARE
501(c)(3)

SEAL! Michigan Program
MDHHS Oral Health Dept

Smiles on Wheels offers children's dental hygiene services at ***no cost to you!***

- Oral Health Assessments and Cleanings
- Dental Sealants
- Fluoride Treatments
- Oral Health Education

A referral note will be sent home after the visit explaining services provided and information to help find a dental home.

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 Act *(HIPAA)*. Your child's information may be shared with school administration and or oral health partners.

Complete the consent form on the other side and check either 'YES' or 'NO' and return to your child's school.
If you have dental insurance, it will be researched, verified, and billed for the services provided. If you don't have dental insurance, services will be provided at **no cost to you.**
You will not receive a bill from Smiles on Wheels.

Program Survey

Your smile and your opinion mean the world to us! Help us keep our care top-notch by taking this quick survey.

ABC's of Oral Health

Scan the QR code for oral health tips for kids.

Smiles on Wheels follows CDC recommendations for proper Infection Control to prevent the spread of communicable diseases. These guidelines can be found on our website www.smilesonwheels.org.

Smiles on Wheels is coming to your child's school!

Smiles on Wheels
Mobile Dental Hygiene Care
501c3 non-profit
www.smilesonwheels.org
facebook.com/mobilehygieneprogam

Questions?
Contact Smiles on Wheels
Jackson: (517) 740-7422
Upper Peninsula: (906) 282-8741
info@smilesonwheels.org

Revised 07/2026

Smiles on Wheels Consent Form

SEAL MI Dental Sealant Program

Event Dates _____ _____

About Your Child

School / Location: _____ Grade: _____ Teacher: _____

Child's Legal Name: _____
(First) (Middle) (Last)

Address: _____ Phone #: _____
(Street) (City) (ZIP)

Date of Birth: ____ / ____ / _____ Age: _____ M or F (Circle One) Parent Email: _____
(Month) (Day) (Year)

Preferred Language (Check one): ☐ English ☐ Spanish ☐ Other (Please Specify): _____

Which of the following describes your child: (Check One or More): ☐ Black/African American ☐ White ☐ Hispanic/Latino ☐ Asian ☐ Arab American ☐ American Indian/Alaskan ☐ Native Hawaiian/Other Pacific Islander ☐ Other

Tooth decay is one of the most common diseases found in children.
Fluoride varnish can be applied to teeth to protect from cavities, and used up to four times a year.

Parent Consent

☐ YES I give my permission for my child to receive: **oral screening, dental cleaning, sealants and fluoride varnish.**

When was your child's last dental cleaning appointment? _____

☐ YES I give my permission for my child to receive: **oral screening and sealants only.**

☐ NO I do not give my permission for my child to receive treatment with Smiles on Wheels

YES / NO (circle one) Smiles on Wheels has my permission to use my child's photo for educational/promotional purposes.

Printed Parent Name _____

Signed Parent Name _____ **Relationship:** _____ **Date:** ____/____/20____

******This consent will be valid for the 12-month period of this program, which may include 2 dental cleaning visits.******

Health History

(Please circle)

YES/NO 1. Is your child allergic to anything? *If yes, what?* _____

YES/NO 2. Is your child taking any medications/supplements? *If yes, what?* _____

YES/NO 3. Does your child have any medical conditions such as heart disease, asthma, hay fever, hepatitis, cancer, diabetes, wear eyeglasses, hearing aids, or any other medical conditions? *If yes, what?* _____

YES/NO 4. Does your child have learning/emotional/physical impairments? *If yes, what?* _____

This line is for office use only 1st visit DOS ___/___/20___ | _____ RDH 2nd visit DOS ___/___/20___ | _____ RDH

Insurance Information

No payment is required from you for this program. **However**, Medicaid/Healthy Kids Dental and other dental insurance carriers are **required to be billed** by the grant program to help cover the cost of services. *****Please complete the required insurance information*****

Medicaid #: _____ Name of Insurance: _____

Insured Name: _____
(First) (Last)

Date of Birth: ____ / ____ / _____ Group #: _____
(Month) (Day) (Year)

Policy or ID #: _____ *OR* Insured SS #: _____ - _____ - _____

Employer: _____ 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 dental insurance benefits that he or she receives from private insurance, a state or federal program, or other third-party provider. Your child will receive a parent letter explaining services completed by Smiles on Wheels. Please take this letter with you to any future dental appointments.

FOR OFFICE USE ONLY

VISIT 1

Data Date: _____ Initials: _____ Billing Date: _____ Initials: _____ Qualtrics Date: _____ Initials: _____ Scan Date: _____ Initials: _____

Notes: _____

VISIT 2

Data Date: _____ Initials: _____ Billing Date: _____ Initials: _____ Qualtrics Date: _____ Initials: _____ Scan Date: _____ Initials: _____

Notes: _____

2nd Visit Calls

Date: _____ Initials: _____ Spoke to? _____ Relationship: _____ LMM: _____ Text Sent: _____ HHx Updated: _____

Ins Updated: Y or N Notes: _____

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