

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. Insurance will be researched, verified, and billed. 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 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 Prophylaxis _____ Varnish _____ Assessment _____ # Teeth _____ Fills _____ Concerns _____
Urgent/Possible Infection # _____ White spots _____ SP Needs yes/no _____ Referral letter given _____ CRA: L M H

NOTES: _____ Lip/Tongue Tie Y or N _____

2nd Visit

Date _____ RDH _____ TB CH Prophylaxis _____ Varnish _____ Assessment _____ # Teeth _____ Fills _____ Concerns _____
Urgent/Possible Infection # _____ White spots _____ SP Needs yes/no _____ Referral letter given _____ CRA: L M H

NOTES: _____ Lip/Tongue Tie Y or N _____