

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.*

<input type="checkbox"/> YES, I give my permission for my child to receive: Fluoride Varnish, Oral Assessment and Toothbrush Dental Cleaning.	Event Site: _____
<input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____ Lip/Tongue Tie _____
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 _____ Lip/Tongue Tie _____
Temp: _____ Pulse Ox: _____
NOTES: _____