



# SEAL! MICHIGAN

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

- ▶ Dental Assessments, Cleanings and Education
- ▶ Sealants
- ▶ Fluoride Treatments

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

**Complete the consent form** on the other side and check either 'YES' or 'NO'. If you have dental insurance, it will be billed for the services provided. If you don’t have dental insurance, services will be provided at **no cost to you.**

**Event Site:** \_\_\_\_\_ **Event Date(s):** \_\_\_\_\_

(Please circle)



**YES/NO** Smiles on Wheels has my permission to use photos of my child for educational or promotional purposes. **Parent/Guardian Initials:** \_\_\_\_\_

*Smiles on Wheels follows CDC recommendations for proper Infection Control to prevent the spread of COVID-19 and all other communicable diseases. These guidelines can be found on our website [www.smilesonwheels.org](http://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](http://www.smilesonwheels.org)  
[facebook.com/mobilehygieneprogram](https://facebook.com/mobilehygieneprogram)

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

# Smiles on Wheels Parent Consent Form

## Dental Sealant & Fluoride Varnish Program

About Your Child

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Child's Legal Name: \_\_\_\_\_  
(First) (Middle) (Last)

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
(Street) (City) (ZIP)

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

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 painted on teeth to protect teeth from cavities. Fluoride varnish can be applied up to four times a year.**

Parent Consent

**YES**, I give my permission for my child to receive: Fluoride, varnish, oral screening, dental cleaning and sealants.  
**When was your last dental cleaning appointment?** \_\_\_\_\_ **Recommended once every 6 months.**

**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.

Printed Parent Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signed Parent Name: \_\_\_\_\_

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

**COVID SAFETY STANDARDS**  
 Smiles on Wheels follows CDC, ADA, and ADHA recommendations and guidelines for proper infection control to prevent the spread of COVID-19 and all other communicable disease.

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? *If yes, what?* \_\_\_\_\_

**YES/NO** 3) Does your child have any medical conditions such as heart disease, asthma, hay fever, hepatitis, cancer, diabetes, or any other medical conditions? *If yes, what?* \_\_\_\_\_

**YES/NO** 4) Does your child have learning or emotional impairments? *If yes, what?* \_\_\_\_\_

Insurance Information

**No payment is required from you for this program.** However, Medicaid/Healthy Kids Dental/MiChild and other dental insurance carriers **will be billed** to help cover the cost of this program. Please fill out 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 #: \_\_\_\_\_

*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).*

*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.*

### FOR OFFICE USE ONLY

**VISIT 1:** Date: \_\_\_\_\_ RDH: \_\_\_\_\_ AD/CH Prophy: \_\_\_\_\_ Varnish: \_\_\_\_\_ Assess: \_\_\_\_\_ # Teeth: \_\_\_\_\_ Fills: \_\_\_\_\_ Concerns: \_\_\_\_\_

SP Needs: \_\_\_\_\_ Urgent/Possible Abscess #: \_\_\_\_\_ Seals: None A B I J K L S T 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29

Notes: \_\_\_\_\_ TEMP: \_\_\_\_\_ O2: \_\_\_\_\_ Referral Faxed: \_\_\_\_\_

**VISIT 2:** Date: \_\_\_\_\_ RDH: \_\_\_\_\_ AD/CH Prophy: \_\_\_\_\_ Varnish: \_\_\_\_\_ Assess: \_\_\_\_\_ # Teeth: \_\_\_\_\_ Fills: \_\_\_\_\_ Concerns: \_\_\_\_\_

SP Needs: \_\_\_\_\_ Urgent/Possible Abscess #: \_\_\_\_\_ Seals: None A B I J K L S T 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29

Notes: \_\_\_\_\_ TEMP: \_\_\_\_\_ O2: \_\_\_\_\_ Referral Faxed: \_\_\_\_\_

**VISIT 3: Sealant Retention Check:** TEMP: \_\_\_\_\_ O2: \_\_\_\_\_

Date: \_\_\_\_\_ RDH: \_\_\_\_\_ All Retained: **Y/N** REPLACED #: 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29 A B I J K L S T  
(circle one)