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!***

- 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.

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 06/2022

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 (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 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 recommedations 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: _____ CRA - L M H (circle one) 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: _____ CRA - L M H (circle one) Referral Faxed: _____

VISIT 3:
Sealant Retention Check: TEMP: _____
Date: _____ RDH: _____ All Retained: **Y / N** (circle one) 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

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