School Smiles
On-site Dental Care

Fax: 888-781-5678 Email: cwright@schoolsmiles.com Toll Free: 1-855-497-6453

A NEW FORM MUST BE COMPLETED EACH SCHOOL YEAR IF YOU WOULD LIKE YOUR CHILD TO PARTICIPATE

SIGN UP TODAY TO SEE THE DENTIST AT SCHOOL!!

Fill out and return to school or Sign Up Online: www.schoolsmiles.com/student-signup

STEP 1 — CHILD'S GENERAL INFORMATION

Child's Legal Name: ______________________________ Birthdate: _____/_____/_____(circle) M F

Address: ______________________________ City: ______________ State: ______ Zip: __________

School: ______________________________ County: ______________ Grade: __________ Class#: ______

Parent/Guardian Name: ______________________________ Phone:(_____)______________

Child's SSN: ☐☐☐ ☐☐ ☐☐☐☐ Email: ______________________________

STEP 2 — PAYMENT INFORMATION: (please check) MEDICAID ☐ PRIVATE INSURANCE ☐ UNINSURED ☐

1. **Medicaid Information:** 10 or 12-digit ID # ☐☐☐☐☐☐☐☐☐☐☐☐

   Managed Care Plan: ______________________________

2. **Private Insurance:**

   Name of **DENTAL** Insurance Company: ______________________________ Ins. Phone: ______________

   Subscriber Name: ______________________________ Subscriber DOB: _____/_____/_____

   Subscriber ID: ______________________________ Subscriber SSN: ____-____-____-____-____-____-____-____-____

3. **Uninsured Dental Options:**

☐ **Self Pay Option:** If you would like your child seen right away you have the option of paying the **reduced $49 fee** which covers their cleaning, x-rays, fluoride, and exam. **The $49 must be paid before the child is seen via money order or calling (1.855.497.6453) to provide payment over the phone.**

☐ **Grant Request Option:** Free dental services available on a first come first serve basis.

STEP 3 — IMPORTANT HEALTH QUESTIONS:

1. Does your child have any present medical conditions such as: heart issues, seizure disorders, allergies, etc? If yes, please list below.

   If NO, leave blank: ______________________________

   ____

STEP 4 — SIGNATURE REQUIRED

I the Parent/Guardian ______________________________ understand and give permission for School Smiles dentists to provide the following services on my child at school which includes: exam, x-rays, cleaning, fluoride, and sealants as needed for 6 month check-ups. I also give permission for my child to receive dental treatment as needed for follow up care in the form of restorative fillings and local anesthetic to numb the area. I understand and consent that during treatment it may be necessary to change or add procedures because of conditions found that were not discovered during the initial exam such as larger fillings or a pulpotomy (root canal on baby tooth). I understand if at any time my child needs a stainless steel crown or an extraction an additional consent will be required.

FINANCIAL STATEMENT: please be aware that any treatment that is rendered may affect future benefits that your child will receive under private insurance, health insurance program, medicaid, and hoosier healthwise. A copy of the School Smiles HIPAA Privacy Notice is included on the back of this form, by signing I also understand that a copy of this will be provided at my child's appointment and an additional copy can be requested by calling 1.855.497.6453.

By signing below you are consenting to routine dental cleanings as well as any necessary dental treatment for one school year and giving the school permission to fax your registration form to School Smiles.

Parent/Guardian Signature: ______________________________ **Date:** ______________

If your child requires treatment outside of what can be provided by School Smiles, a referral will be provided to you.

English