





Fax: 888-781-5678 Email: patientforms@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

CHILD'S GENERAL INFORMATION  Child's Legal Name:   Birthdate:   (circle) M F Address:   City:   State:   Zip:    Address:   County:    Grade:   Days Attend:   Classroom#:    Parent/Guardian:   Phone:     I consent to receive healthcare messages from School Smiles.  PAYMENT INFORMATION: (please check)   MEDICAID   PRIVATE INSURANCE   UNINSURED    1. Medicaid Information: 10 or 12-digit ID #		- This out and retain to some of orgin op omine: www.someo.com/stadent signap
Address: City: State: Zip: School: County: Grade: Days Attend: Classroom#: Parent/Guardian: Phone-( )		CHILD'S GENERAL INFORMATION
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Managed Care Plan:  2. Private Insurance: Name of DENTAL Insurance Company: Subscriber Name: Subscriber DOB:  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: Dental services available on a first come first serve basis. ***Only available to those without dental insurance. Additional documentation may be required to confirm financial eligibility.**  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:  SIGNATURE REQUIRED  Ithe Parent/Guardian of 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, silver diamine fluoride, and sealants as needed for 6 month check-ups. I also give permission for my child to receive, on the same day as the exam, or scheduled as needed, any additional dental treatment in the form of restorative fillings, with a pulpotromy if needed, any additional cort and no haby toolship, space maintainers, and extractions (guilling the tools) to numb the area. In understand that burdent in the form of restorative fillings, with a sploptomy if needed to local metaltectic to numb the area. In understand that burdent and a copy of the School Smiles, a referral will be available to you.  By stigning below, I am consenting to routine dental cleanings as well any necessary dental treatment for one school year and give permission for this registration form to be faxed, emailed, or mailed to School Smiles.  Parent/Guardian Signature:  Date:	TEP	PAYMENT INFORMATION: (please check) MEDICAID PRIVATE INSURANCE UNINSURED
2. Private Insurance: Name of DENTAL Insurance Company: Subscriber Name: Subscriber Name: Subscriber DOB: Subs		1. Medicaid Information: 10 or 12-digit ID #
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