School Smiles
On-site Dental Care

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

STEP 1 — CHILD'S GENERAL INFORMATION

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

Address: _____ City: _____ State: _____ Zip: _____

School: _____ County: _____

Grade: _____ Days Attend: _____ Classroom#: _____

Parent/Guardian: _____ Phone:(_____)_____

Email: _____

I consent to receive healthcare messages from School Smiles.

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:**

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

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 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 pulpotomy if needed, and local anesthetic to numb the area. I understand that during treatment it may be necessary to change or add procedures the same day because of conditions found that were not discovered during the initial exam which includes: larger fillings, stainless steel crowns, pulpotomy (root canal on baby tooth), space maintainers, and extractions (pulling the tooth).

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, and Medicaid.
* Please note: If your child needs treatment beyond fillings, such as stainless steel crowns, pulpotomies or extractions, additional consent WILL be required from you. If your child requires treatment outside of what can be provided by School Smiles, a referral will be available to you.

I understand a copy of the School Smiles HIPAA Privacy Notice will be provided at my child's appointment and a copy can also be found at https://schoolsmiles.com/schools/forms/.

By signing 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:** _____

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