SchoolSmiles
On-site Dental Care

SAVE TIME!
Call 1.855.497.6453
to sign up your child over the phone
or register at www.schoolsmiles.com

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

Taking care of your child's teeth is important to keep them healthy.

DENTAL SERVICES FOR ALL AT NO COST TO YOU*

*for Medicaid and Grant Approvals

This program is **EASY** and **CONVENIENT**: A state licensed dental team comes directly to the school to provide regular dental cleanings and follow up care as needed. There is no more need to miss work and your child misses minimal classroom time. **FREE DENTAL SUPPLIES PROVIDED TO ALL IN THE PROGRAM!** School Smiles can become your child's dental home!

CHILD'S GENERAL INFORMATION

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

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

School: _____ **County:** _____ **Grade:** _____

Parent/Guardian Name: _____ **Phone:** _____

Child's SSN: ☐☐☐ - ☐☐ - ☐☐☐☐

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 $99 fee which covers their cleaning, x-rays, fluoride, and exam. The $99 must be paid before the child is seen via money order or calling (1.855.497.6453) to provide over the phone.

☐ **Grant Request Option:** If you would like to be added on our waitlist for a grant approval please check this box. You will be notified when your child has been approved. This is a first come first serve option.

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: _____

SIGNATURES 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, silver diamine fluoride, and sealants as needed for 6 month check-ups. I also give permission for my child to receive dental treatment as needed in the form of restorative fillings and local anesthetic to numb the area and any changes. I understand that during treatment it may be necessary to change or add procedures because of conditions found that were not discovered during the initial exam. For example: larger fillings, stainless steel crowns, pulpotomy (root canal on baby tooth) and extractions (pulling the tooth).
FINANCIAL STATEMENT: please be aware that any treatment that is rendered may affect future benefits that your child will recieve 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 I am consenting to routine dental cleanings as well as any necessary dental treatment for one school year:

Parent/Guardian Signature: _____ **Date:** ____/____/____

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