**TRAVELING SMILES**

**Miami County Portable Dentistry**

Dear Parent/Guardian:

We are pleased to inform you about and exciting opportunity for your child to be a part of a comprehensive oral health program. The Miami County Dental Clinic is proud to announce that our dental team will be at THE TROY REC to provide dental services ***to those children that do not have a family dentist and/or see a dentist on a regular basis.***

As dental professionals, we recognize the need for dental care for our children and want to help schools and parents in our community by providing this care. We are committed to providing high-quality dental services with a strong focus on preventing disease using the most current dental technology and equipment.

**The benefits of the program are**:

* Your child will be comfortable in the environment of the Troy Rec, surrounded by friends and staff with the familiar sights and sounds to which they are accustomed
* Parents save money on lost wages and travel expenses when they have to take their child to the dentist.
* Parents will receive a comprehensive report on the services the child receives, your child’s oral health condition and other recommendations that may include referrals for more complex procedures

Using portable dental equipment, our services include:

* Dental exam and diagnosis—learn what dental treatment your child needs
* Cleaning—remove bacteria that causes cavities and gum disease
* Fluoride treatment—fluoride makes teeth stronger to prevent cavities
* Dental sealants—seal over the deep grooves on the chewing surfaces of back teeth to prevent your child from getting cavities
* Minor fillings—remove decay from your child’s teeth and put in a filling to restore the tooth’s function. This may also include the application of a local anesthetic Novocain.
* Referral—if your child requires more advanced dental procedure

Please return the attached permission form to your child’s school as soon as possible so that we can begin to help your child in the prevention and treatment of dental disease.

A letter will be sent home after each appointment, stating what services your child has received as well as what additional services are needed.

**CONSENT FOR YOU CHILD**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Name of Child)*

I give permission for my child to be examined and /or treated by the dental provider representing Miami County Portable Dentistry in conjunction with the Miami County Dental Clinic.

I understand that dental treatment may include any or all of the following**: Dental Exam and Diagnosis, X-rays, Dental Cleaning, Oral Hygiene Instruction, Topical Fluoride Application, Preventative Sealants, Fillings, Other Restorative Dentistry and Recall Visits.**

I give permission for my child to have fillings with the possible application of local anesthetic xylocaine most commonly called “Novocain”

I understand that this consent will stay in effect while my child attends this school, or upon retraction of this consent.

It is the parent/guardian’s responsibility to inform the dental provider and /or the school nurse of any changes in the child’s medical history and insurance information.

I understand that the patient’s health information may be used for treatment, payment and health care operations.

If I have dental insurance, I authorize my insurance carrier to be billed for any services provided.

I consent to have my child’s picture taken for community relations purposes. No name will be provided

I have read and understand the dental program and I consent to have my child participate.

\_\_\_\_\_YES, I give permission for my child to participate in the dental program. (sign below)

\_\_\_\_\_NO, I do not give permission for my child to participate.

\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the Child and Date

**CHILD’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SCHOOL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MIAMI COUNTY PORTABLE DENTISTRY**

**ORAL HEALTH SERVICES REGISTRATION FORM**

*If your child has a family dentist that he/she visits on a regular basis please continue to see that provider.* If you would like to arrange for your child to receive dental services at school, please complete all forms and return them to school as quickly as possible.

**PATIENT INFORMATION**

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Contact Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child received dental treatment this past year? Yes\_\_\_\_\_ No\_\_\_\_\_\_

If yes what and when was the treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last date seen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My child has a Primary Care Physician Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

Name of Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Complete All *Applicable* Information Below**

Private Dental Insurance or Medicaid Information

Insurance Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier Name (parent) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid/DentaQuest/Caresource Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Social Security # if Private Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Social Security # (Medicaid or Dentaquest) \_\_\_\_\_\_\_\_\_\_

**CHILD’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

Does your child need to be pre-medicated for any medical condition prior to a dental procedure? Yes\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do Not Know \_\_\_\_\_\_\_\_\_\_\_\_

If yes, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your child have or has he/she ever had the following? (Check where appropriate)**

YESNO

Heart Murmur/heart disease \_\_\_\_ \_\_\_\_

Rheumatic fever/heart disease \_\_\_\_ \_\_\_\_

Kidney problems \_\_\_\_ \_\_\_\_

Lung problems \_\_\_\_ \_\_\_\_

AIDS/ARC/HIV infection \_\_\_\_ \_\_\_\_

Allergies-food, drugs, insect bites

Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fainting or dizziness \_\_\_\_ \_\_\_\_

Diabetes (or family history) \_\_\_\_ \_\_\_\_

Anemia (thin blood) \_\_\_\_ \_\_\_\_

HIV antibody positive \_\_\_\_ \_\_\_\_

Liver problems \_\_\_\_ \_\_\_\_

Sinus problems/hay fever \_\_\_\_ \_\_\_\_

Nervous Disorders \_\_\_\_ \_\_\_\_

Sexually transmitted disease \_\_\_\_ \_\_\_\_

Epilepsy/Seizures \_\_\_\_ \_\_\_\_

Hypertension (high blood pressure) \_\_\_\_ \_\_\_\_

Stomach or intestine problems \_\_\_\_ \_\_\_\_

Any hospitalizations other than birth \_\_\_\_ \_\_\_\_

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Broken bones/pins \_\_\_\_ \_\_\_\_

Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have or ever had any disease or condition not mentioned above?

(Please describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature** (I consent that the above information is correct to the best of my knowledge.)