

Smiles on Wheels is coming to your child's school!

Smiles on Wheels offers children's dental hygiene services at no cost to you!

- ▶ Dental screenings, cleanings and education
- ▶ Sealants
- ▶ Fluoride treatments

A referral note will be sent home after the visit explaining services provided and information to help find a dental home, if needed.

Complete the attached consent form to help your child have healthy teeth! If you have dental insurance, it will be billed for the services provided. If you don't have dental insurance, services will be provided at no cost to you.

Event Site: _____

Event Date(s): _____



“I know it's important to keep my son's teeth healthy, but it's hard for me to take off work to bring my son to the dentist. Smiles on Wheels came right to the school so my son could get sealants. I feel better knowing his teeth are protected.”

Smiles on Wheels
Mobile Dental Hygiene Care
501c3 non-profit
www.smilesonwheels.org

Questions?
Contact Smiles on Wheels
Jackson: (517) 740-7422
Upper Peninsula: (906) 221-2389
smilesonwheels@hotmail.com

 DELTA DENTAL®

SEAL!
MICHIGAN

Smiles on Wheels Parent Consent Form

Dental Sealant & Fluoride Varnish Program

School: _____ Grade: _____ Teacher: _____

Child's Legal Name: _____
(First) (Middle) (Last)

Address: _____ Phone #: _____
(Street) (City) (ZIP)

Date of Birth: ____/____/____ Age: _____ Male or Female Cell Phone #: _____
(Month) (Day) (Year) (Check One)

Preferred Language (Check One): English Spanish Other (Please Specify): _____

Which of the following describes your child (Check One or More): Black/African American White Hispanic/Latino
 Asian Arab American American Indian/Alaskan Native Hawaiian/Other Pacific Islander Other

Tooth decay is one of the most common diseases found in children. Fluoride varnish can be painted on teeth to protect teeth from cavities. Fluoride varnish can be applied up to four times a year.

- YES, I give my permission for my child to receive: Fluoride varnish, oral screening, dental cleaning and sealants, if needed.
- YES, I give my permission for my child to receive: Oral screening and sealants only.
- NO, I do not give my permission for my child to receive treatment with Smiles on Wheels.

Printed Parent Name: _____ Date: _____

Signed Parent Name: _____

This consent will be valid for the 12-month period of this program.

(Please Circle):

- YES/NO 1) Is your child allergic to anything? If yes, what? _____
- YES/NO 2) Is your child taking any medications? If yes, what? _____
- YES/NO 3) Does your child have any medical conditions such as heart disease, asthma, hay fever, hepatitis, cancer, diabetes, or any other medical conditions? If yes, what? _____
- YES/NO 4) Does your child have learning or emotional impairments? If yes, what? _____

No payment is required from you for this program. However, Medicaid/Healthy Kids Dental/MiChild and other dental insurance carriers will be billed to help cover the cost of this program. Please fill out insurance information.

Medicaid #: _____ Name of Insurance: _____

Insured Name: _____
(First) (Last)

Date of Birth: ____/____/____ Group #: _____
(Month) (Day) (Year)

Policy or ID #: _____ OR Insured SS #: _____ - _____ - _____

Employer: _____ Employer Phone #: _____

Your child's personal information will be kept confidential and will not be shared with any person who is not directly involved in the care of your child as part of the Health Insurance Portability and Accountability Act (HIPAA).

Dental services may be obtained at the patient's dental home rather than with the mobile dental facility and obtaining duplicate services may affect insurance benefits that he or she receives from private insurance, a state or federal program, or other third-party provider of dental benefits.

FOR OFFICE USE ONLY

VISIT 1: Date: _____ RDH: _____ AD/CH Prophy: _____ Varnish: _____ Screen: _____ # Teeth: _____ Fills: _____ Cavities: _____
 SP Needs: _____ Urgent Care/Abscessed #: _____ SEAL #: NONE 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29
 Notes: _____

VISIT 2: Date: _____ RDH: _____ AD/CH Prophy: _____ Varnish: _____ Screen: _____ # Teeth: _____ Fills: _____ Cavities: _____
 SP Needs: _____ Urgent Care/Abscessed #: _____ SEAL #: NONE 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29
 Notes: _____

VISIT 3: Sealant Retention Check:
 Date: _____ RDH: _____ All Retained: _____ REPLACED #: 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29

About Your Child

Parent Consent

Health History

Insurance Information

VISIT 1:

VISIT 2:

VISIT 3: