MOBILE SMILES

CONSENT FOR SERVICES

Any block or line with a * must be completed or treatment cannot be rendered!

***Student Name**
Last Name : _____ **First Name:** _____ **Middle Initial:**_____

***Names of other children attending this school :**_____ **(Consent form required for each child)**

***Gender (circle one) : Male / Female** ***Student's Birth Date (MM/DD/YY):** ___/___/_____

***Email Address :** _____

Home Phone: (___)**_____Cell Phone: (___)**_____ **Alternate: (___)**_____

Teacher Name:** _____Grade:** _____***School:**_____

***Student's Home Address:**

_____
Street City State Zip

***Parent/Guardian's Name:** _____ ***Relationship to Child:** _____

***Parent/ Guardian would like to be present during appointment. ____Yes ____No**

MEDICAL QUESTIONS

***Child's Dentist if applicable:** _____
***Date of last dental cleaning? If unsure has it been longer than six months ago** _____
***Child's Doctor:** _____

***Does your child have allergies (including latex)?**	☐ **Yes**	☐ **No**	☐ **Unsure**
If yes please list: _____			
Does child need antibiotics prior to treatment?	☐ **Yes**	☐ **No**	☐ **Unsure**
***Has your child ever had an artificial joint replacement?**	☐ **Yes**	☐ **No**	☐ **Unsure**
***Has your child ever been diagnosed with rheumatic fever?**	☐ **Yes**	☐ **No**	☐ **Unsure**
***Does your child currently have sickle cell anemia?**	☐ **Yes**	☐ **No**	☐ **Unsure**

***List any serious health problems your child has now:** _____

***List any medication your child is taking at this time:** _____

PAYMENT INFORMATION

PAYMENT INFORMATION - YOU MUST COMPLETE SECTION A,B, OR C AND SIGN AT BOTTOM

A. ☐ MEDICAID: **Medicaid ID:**_____ **(Child's Medicaid or CHP+ number):** _____

B. ☐ DENTAL INSURANCE: **Dental Insurance:** _____ **Name of Parent or Guardian Who Has Insurance:** _____ **Name of Dental Insurance:**_____
Address of Insurance Company:_____
Street City State Zip
Birth Date of Primary Insured (MM/DD/YY): ___/___/_____**Name of Company Insured Person Works for:** _____ **Insurance ID#:** _____
Dental Insurance Company Phone: (___)_____ **Group Number:** _____

*If student is not covered by dental insurance of Medicaid, private pay is available for a discounted fee. Fee schedule can be obtained at 719-351-0524. If box C is checked then parent/guardian assumes responsibility for payment. Services will not be rendered until fees are paid in full.

C. ☐ My child does not have Medicaid or Dental insurance, I assume responsibility of payment.

*I request and authorize Mobile Smiles and licensed dental hygienists to perform any preventative dental procedures on my child. I understand that preventative services do not take place of an examination by a licensed dentist. I further understand that if my child is not enrolled in Medicaid or other dental insurance I am financially responsible for full payment I request and authorize the release of any information on this form and acquired in the course of treatment for payment, referral purpose, and to all appropriate school personnel as deemed necessary by Mobile Smiles.

_____ _____
***Parent/Guardian Signature (Must Be Signed)** ***Date**

THIS CONSENT WILL BE VALID FOR ENTIRE SCHOOL YEAR.