SMILE SAVERS
MOBILE DENTAL HEALTH SERVICE
514 Edwin Avenue
Kalamazoo, MI 49048

PARENT PERMISSION SLIP

I _____ give Smile Savers permission
(Parent/Guardian)
to perform the needed preventative dental services on

_____
(Child's Full Name)

Services being performed are cleanings, fluoride, sealants and dental education. A form will be sent home with the child indicating what services were done on that day and what will need to be done at the next visit. For emergencies, call 269-349-2641. Treatment may be obtained from the patient's dental home, which may result in duplicate of services if patient is covered under another dental insurance.

_____ _____
(Parent Signature) (Date)

**No, I do not give my permission for my child to receive:

__Fluoride __Cleaning ___Sealants

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PATIENT INFORMATION
UNDER 18

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Cell_____ Work_____

E-Mail _____

Circle which option you want us to contact you regarding appointments:

Call Home Call Work Call Cell Text E-Mail

Date of Birth_____

Parents/Guardians Name_____

BILLING INFORMATION

__ Child has Medicaid/MiChild_____

__ Child has no Dental Insurance

Consent for Minor

Since_____is a minor, it is necessary that a signed permission is obtained from a parent or legal guardian before dental services can be started by SMILE SAVERS. Such authorization is hereby granted to administer preventative treatments for my child as deemed necessary. The child can be treated at their dental home rather than a mobile dental services, if the parent prefers. I understand I will be consulted before any treatment is done. Obtaining services from Smile Savers may result in duplicate services which can effect benefits from other dental insurance you receive.

Parent's/Guardian's signature_____ Date_____

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CHILD DENTAL AND MEDICAL HISTORY

Patients Name_____
Last First M.I. Date of Birth

Parents Name_____
Last First M.I.

DENTAL HISTORY-Circle appropriate answer

1. Is this the childs first visit to the dentist?.....yes no
2. If not, how long since last visit?_____
3. Does your child brush in the morning and at night?.....yes no
4. Do you live in an area without fluoridated drinking water?..... yes no
5. Have your childs teeth been treated with fluoride?.....yes no
6. Have any teeth been extracted/removed?.....yes no
   Was a space maintainer suggested?.....yes no
7. Any injuries to the teeth, such as falls, blows?.....yes no
8. Has your child had any unpleasant dental experiences?.....yes no
9. Has your child ever received local anesthetics?..... yes no
10. Has your child ever had sealants placed?.....yes no
11. Any thumbsucking, cheek, lip, nail biting?.....yes no

MEDICAL HISTORY

1. Is your child in good health?.....yes no
2. Is your child under the care of a physician?.....yes no
   If yes, since when and why?_____
   _____
3. Name of child's physician?_____
4. Has your child had any serious illness?.....yes no
   When_____ What_____
5. Has your child ever had any surgery?.....yes no
6. Does your child have any allergies?.....yes no
7. Is your child allergic to penicillin, other anitbotics, any other drugs?..... yes no
   If yes,please list_____
8. Is your child taking any medications at this time?.....yes no
9. Has your child had any of the following(circle appropriate answer): diabetes, heart trouble, asthma, kidney problems, rheumatic fever, heart murmer, toothache, ear infection?

Parents/Guardian's signature_____
Date_____

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HIPAA RELEASE OF INFORMATION

AUTHORIZATION FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability Accountability Act of 1996 (HIPAA). I understand by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment, includes direct and indirect treatment by other healthcare providers involved in my treatment
- Obtaining payment from third party payers (my insurance company)

I have also been informed of and given the right to review and secure a copy of Smile Savers Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Smile Savers reserves the right to change the terms of this notice and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosures that occurred prior to the date I revoke this consent is not affected.

Printed Name_____

Signature_____

Relationship to patient_____

Date_____