

We can't see your child if we don't have your signature on this form.

Smart Smiles Dental Care, LLC

DOES YOUR CHILD NEED DENTAL SERVICES?

We will be visiting your school soon to offer dental services.
Smart Smiles Dental Care, LLC, a portable school-based dental clinic, can help!

This program is for children enrolled in the New Mexico MEDICAID program. Free Dental Screenings for Non-Medicaid Children enrolled upon request.

YES, please see my child. They ARE ENROLLED in Medicaid.
 YES, please see my child. They ARE NOT ENROLLED in Medicaid but have insurance or self pay.
 YES, FREE SCREENING ONLY. I understand this does not include a cleaning. Date of Birth _____
 NO, my child sees a dentist. Dentist Name _____ Date Last Seen _____
 Child's Name _____ Date of Birth _____ Grade _____ Teacher's Name _____
 Signature of Parent/Guardian _____ Print Name of Parent _____ Date _____

CONSENT FOR TREATMENT

I have read, or have had read to me, and I understand the information on this form. All my questions were answered to my satisfaction. I hereby give my permission for the dental professionals of Smart Smiles Dental Care, LLC to treat my child. This consent shall continue in force for the school year.

- YES _____ NO _____ FREE SCREENING ONLY for **NON-MEDICAID STUDENTS**
 YES _____ NO _____ Hygiene Assessment with X-rays (x-rays help to see cavities between the teeth and see new teeth developing)
 YES _____ NO _____ Cleaning with Fluoride Treatment (fluoride helps to reduce the incidence of cavities)
 YES _____ NO _____ Dental Sealants (This is a resin type coating placed on molars to help prevent cavities. It requires no dental injections)

Upon completion of such treatment, my child will receive a form stating what services were performed, and if cavities were found, or further dental treatment is needed. Smart Smiles Dental Care, LLC is authorized to furnish any and all records in their possession to any licensed dentist upon request.

CHILD'S INFORMATION

Child's First Name _____ Middle Name _____ Last Name _____ Male _____ Female _____
 Full Address _____ City _____ Zip Code _____
 Parent/Guardian's Name _____ Home Phone # _____ Work or Emergency # _____
 School _____ Grade Level _____ Teacher _____
 Child's Dentist (if any) _____ Child's Medical Doctor _____

MEDICAID/INSURANCE BILLING INFORMATION

Child's Name Exactly as on Medicaid Card _____
 Child's Social Security Number _____ - _____ - _____ Date of Birth _____ - _____ - _____
 Private Insurance _____ Policy # _____ ID # _____

MEDICAL HISTORY

Medical Questions must be answered before treatment.

If there is a medical condition which requires pre-medication (including HEART MURMERS) please let us know.

YES _____ NO _____ Heart Murmur	If so, is it resolved per child's medical doctor YES _____ NO _____
YES _____ NO _____ Rheumatic Fever	Date of Occurrence _____
YES _____ NO _____ Asthma	Medication _____ How Often _____
YES _____ NO _____ AIDS/HIV Virus	Medication _____ How Often _____
YES _____ NO _____ Diabetes	Date of Occurrence _____
YES _____ NO _____ Hepatitis	Date of Treatment _____
YES _____ NO _____ Mitral Valve Prolapse or Artificial Heart Valve	
YES _____ NO _____ Tuberculosis	
YES _____ NO _____ Latex Rubber Allergy	
YES _____ NO _____ Drug Allergies	Please List _____
YES _____ NO _____ Learning Disabilities or Special Needs	Please List _____
YES _____ NO _____ Any Other Health Problems	Please List _____
YES _____ NO _____ Currently Taking Any Medication	Please List _____
YES _____ NO _____ Currently under the care of a Dentist	Please List Dentist's Name _____

Smart Smiles Dental Care, LLC employs licensed professionals. We are a Medicaid Provider. We are committed to maintaining the confidentiality of your child's personal and health information. We are not part of your child's school system. The school system is not responsible for the services Smart Smiles Dental Care, LLC provides.

IF YOU HAVE QUESTIONS, PLEASE CALL: 575-302-6677 - Peggy Hyden, RDH, BS OWNER/COORDINATOR