DENTISTS R US

A School Based Mobile Dental Program

Dentists R US
38865 Dequindre Rd, #105
Troy, MI 48083
888-226-7129 OR 248-879-7755
www.Dentistrus.com

IF YOU WOULD LIKE FOR YOUR CHILD TO PARTICIPATE IN THE DENTAL PROGRAM, YOU MUST COMPLETE THE INFORMATION BELOW. SIGN AND RETURN THE FORM TO YOUR SCHOOL

PARENTS/GUARDIAN

Dental services will be provided by Licensed Dentists and Hygienists at your child's school. Dental treatment includes an Oral Exam, Cleaning, Fluoride, Sealants and necessary X-Rays. **AN ORAL HEALTH REPORT** and **FREE TOOTHBRUSH** will be provided to each child.

Patient (Student) Information (Please Print)

School Name:_____ **Teacher:**_____ **Grade:**_____

Student Name:_____ **Date of Birth:**_____ **Sex:**_____

Home Address:_____ **City:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____ **Date Of Last Dental Cleaning:**_____

HEALTH HISTORY- IMPORTANT. MUST BE FILLED OUT COMPLETELY

Has your child had any history of, or conditions related to, ANY of the following? Check ALL that apply:

☐ AD/HD	☐ Seizures	☐ Anemia	☐ Asthma	☐ Bleeding Disorders	☐ Blood Disorders
☐ Cancer	☐ Cerebral Palsy	☐ Chronic Sinusitis	☐ Diabetes	☐ Ear Aches	☐ Epilepsy
☐ Fainting	☐ Hearing Problem	☐ Heart	☐ Heart Murmur	☐ Latex Allergy	☐ Growth Problems
☐ Thyroid	☐ Tobacco/ Drug Use	☐ Pregnancy (teens)	☐ Allergies_____	☐ Other:_____	

Medications Please List: _____

MEDICAID/ MICHILD (COVERS 100% OF SERVICES) AND PRIVATE INSURANCE ACCEPTED

**********We Do ALL The Paper Work And Bill Your Insurance Directly*************

Enter Child's 8 or 10 digit MEDICAID/ MI CHILD Number Below

Students Social Security (For Billing Purpose) __ __ __ __ - __ __ - __ __ __ __

NAME OF OTHER DENTAL INSURANCE:_____ **PHONE NUMBER:**_____

IDENTIFICATION #_____ **INSURED DATE OF BIRTH:**_____

NAME OF PARENT UNDER WHOM THE CHILD IS COVERED _____

SOCIAL SECURITY # OF PARENT UNDER WHOM THE CHILD IS COVERED _____

If NO Dental Insurance Check the Box That Best Applies To You

☐ I will pay a **Reduced Fee of $35.00** for cleaning, exam, fluoride, due to financial hardship, and will sign **Reduced Fee Waiver:**

(I am unable to pay FULL Fee) Parent/ Guardian_____

Please attach payment (cash, check, or money order) to this form. **Payable to: Healthy Smiles**

☐ I can pay the full fee for the cleaning, exam, and fluoride (Please call 248-879-7755 for full fee schedule)

☐ Financial assistance- I have **NO** dental Insurance/ Medicaid, **AND** my child is on the free or reduced lunch program.

6- Month Recall?

Dentists R US will provide a 6-month recall visit for participating schools.

Would you like your child to receive a dental cleaning and exam again in six months?

☐ YES / ☐ NO

The American Academy of Pediatric Dentistry (AAPD) recommends children visit the dentists at least every six months (twice a year)

Parents Initials: _____

I (Parent/ Legal Guardian) give Dentists R US/ Healthy Smiles permission to perform dental services on my child, I certify that I have read and understood the above information to the best of my knowledge. I authorize and request my insurance company to pay Dentists R US on my behalf. I have reviewed Notice of Privacy Practice (HIPPA), on DENTISTRUS.COM. I authorize the school nurse/ staff, and/or dentist of my preference to obtain my child's dental records. Please take oral health report to child's present provider if additional dental services are needed.

PARENT/ GUARDIAN SIGNATURE (REQUIRED) _____ **Date:** _____

Office Use Only

Method of Payment

Cash_____ Check_____ Insurance _____

Dentist's Initials_____

Hygienist/Staff Initials_____