SMILES TO GO
We Bring Our Dental Team To You!

Dentists R Us

Coming to your school

THIS FORM MUST BE FILLED OUT IN ORDER TO PARTICIPATE IN OUR INITIAL DENTAL SERVICE AND 6-MONTH FOLLOWUP

PARENTS/GUARDIAN

Dental services are provided by Licensed Dentists and Hygienists **at your child's school**. Dental treatment may include 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:

☐ Anemia ☐ Asthma/Emphysema ☐ Cancer ☐ Bleeding Disorder ☐ Cerebral Palsy ☐ Diabetes ☐ Fainting/Epilepsy/Seizures ☐ Kidney Disease

☐ Congenital Heart Disease ☐ Heart Murmur ☐ Latex Allergy ☐ Growth Problems ☐ Tobacco/ Drug Use ☐ Pregnancy (teens) ☐ HIV/AIDS

☐ Liver Disease/Hepatitis ☐ Thyroid Disease ☐ Joint Replacement ☐ Tuberculosis ☐ Allergies_____

☐Other:_____ Need pre-medication before treatment? (Y / N) **Please List Medications:** _____

DENTAL INSURANCE INFORMATION

☐ **My child has MEDICAID/MI CHILD (covers 100% of cost)**

Medicaid ID Number:

Social Security Number (for billing purposes only):

___ ___ ___ - ___ ___ - ___ ___ ___ ___

☐ **My child has private dental insurance**

Name of Dental Insurance _____

Phone Number _____

ID# _____

Name of Parent under whom child is covered _____

Date of Birth of Insured Adult _____

Social Security Number of Insured Adult _____

Please note: HMO policies are not accepted

☐ **My child has no dental insurance.**

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

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

You will be receiving a reminder call prior to our return visit. If you do not wish to have your child seen, please contact our office before the visit.

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

FOLLOW-UP CARE

- An oral health report will be sent home after every visit indicating any necessary follow-up treatments (fillings, extractions, etc.).
- **Follow-up treatment is available at our dental office: 38865 Dequindre Rd. Suite #105, Troy, MI (248) 879-7755**
- X-Rays and reports can be sent to the dental office of your choice.

I (Parent/ Legal Guardian) give Dentists R US/Healthy Smiles permission to perform an initial oral exam, cleaning, fluoride, sealants, necessary X-Rays, and a 6-month check-up (cleaning, fluoride, sealants)on my child; *I understand that these services may occasionally cause minor discomfort upon completion. I authorize and request my insurance company to pay Dentists R Us on my behalf. I understand that I am responsible for any deductibles and copays from my private insurance. I understand that* ***services received through a mobile dental program may affect my benefits if services are duplicated at a home dental office within a six month time period. 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. Call our office for more information and questions. I certify that I have read and understood*** *the above information to the best of my knowledge.*

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

Office Use Only

Method of Payment

Cash_____ Check_____ Insurance Billed_____ Date:_____

MI____ MA____

PI____ PA____

Dentist's Initials_____

Hygienist/Staff Initials_____

Dr. Darshika Shah DDS, Dr. Sheretta Oates DDS, Dr. Clifford Heller DDS, Dr. Khayri Kassab DDS, Dr. Michael Pang DDS, Dr. Suela Veizaj DDS, Dr. Parneet Virk DDS

38865 Dequindre Rd, Suite #105, Troy, MI 48083 Emergency (24-Hour Service) (248) 879-7755 www.dentistrus.com