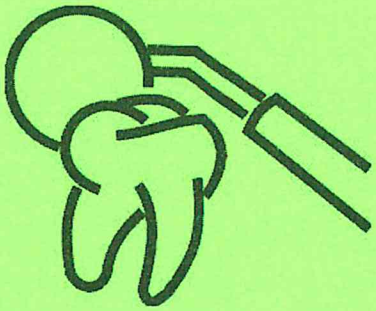

DENTISTS R US

WILL BE AT YOUR SCHOOL ON:

WEd. Oct. 10th

Licensed Dentists & Dental Hygienists will be available to perform:

COMPREHENSIVE DENTAL EXAMS

PROPHYLAXIS (DENTAL CLEANING)

FLUORIDE TREATMENTS

X-RAYS (IF NEEDED)

SEALANTS (WHEN NECESSARY)

BONUS: EACH PARTICIPANT WILL RECEIVE A FREE TOOTHBRUSH!

An Oral Health Report will be sent home to parent.

If you would like your child to be seen, please fill out the Permission Slip and return to the office prior to the above service date.

NOTE: Students who had a cleaning within the last 6 months, are NOT eligible.

DENTISTS R US PROMOTES ORAL HEALTH HYGIENE WITH PERSONALIZED INSTRUCTIONS & EDUCATION

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

☐ 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

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).

IF NO DENTAL INSURANCE CHECK THE BOX THAT BEST APPLIES TO YOU

☐ **(I am unable to pay FULL FEE)** I will pay a **Reduced Fee of $35.00 (CHECK PAYABLE TO HEALTHY SMILES)** for cleaning, exam, fluoride, due to financial hardship, and will sign **Reduced Fee Waiver: Parent/Guardian**_____

☐ Financial Hardship- I have **NO** dental Insurance/ Medicaid. Please call for assistance at **(248)268-2093**

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 O** 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 treatment may be obtained at patient's dental home rather than mobile dental facility, and that obtaining duplicate services at a mobile facility may affect benefits that he/she receives from a private insurance, a state or federal program, or other third-party provider of dental benefit. I have reviewed Notice of Privacy Practice (HIPPA), on the back of this form. 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:** _____

Dentist's Initials_____ **Hygienist/Staff Initials**_____