

SmileHealthy Mobile Clinic

Treatment Consent and Medical Information Form

ADMIN. USE
ONLY:

Present: _____

Absent: _____

PLEASE PRINT USING INK

SmileHealthy has arranged for dental services for you or a child under your care which may include an exam, cleaning, fluoride treatment, sealants and in some cases restorative care. Licensed Dentists, Hygienists, and Assistants will perform at the clinic with portable dental equipment. In addition you or the child may receive fillings, extractions and anesthetic based on the treatment performed at a restorative clinic. You or the child may also receive x-rays.

1 Patient's Information

School/Site Name: _____ Grade/Classroom _____ A.M. P.M.

Name: _____

Home Address: _____ Apt. # _____

City: _____ Zip: _____ County: _____

Date of birth: ____/____/____ Sex: Male / Female Phone number: (____)____-____

Race (check all that apply, for research purposes only, not required for eligibility):

- | | | | |
|-------------------------------------------------|---------------------------------------------------------|--------------------------------|-------------------------------------------|
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Non-Hispanic | <input type="checkbox"/> White | <input type="checkbox"/> African American |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> American Indian/Alaskan Native | | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Unknown | | |

2 Patient's Insurance Information

Do you or the child qualify for and receive benefits from Medicaid, KidCare, AllKids, or Medical Card? Yes / No

IF YOU CIRCLED "YES", YOU MUST COMPLETE THE FOLLOWING:

9-Digit Number on Medicaid card: _____

Are you or the child covered by private dental insurance plan? Yes / No If you circled Yes, please provide:

Insurance Co. Address: _____

Insurance Co. Name: _____ Group or Policy #: _____

Identification #: _____

Employer Name: _____ Insurance Co. Phone: (____)____-____

Name of Policy Holder: _____ Employer Phone: (____)____-____

Policy Holder Birthdate: _____ Policy Holder's Social Security Number: _____

3 Patient's Medical History

If you have no medical conditions, please initial here: _____

Please check the box of any condition you or the child may have had or are currently suffering from:

- | | | |
|---------------------------------------------------------|------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Artificial Heart Valve |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Allergy to Latex/Colored Dyes |
| <input type="checkbox"/> A.I.D.S./HIV Positive or Other | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Cardiac Surgery |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> High/Low blood Pressure | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other medical conditions | <input type="checkbox"/> Oral Contraceptives | |

If you checked any of the boxes, please explain: _____

Please list any medications you or the child are taking: _____

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I or the child I am caring for is entitled. I authorize the dentists to release any information, including the diagnosis and the records of any treatment or examination rendered to me or the child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. If no current public or private dental insurance plan is made available to the provider, I understand that I may be billed for the services provided. Patients without insurance will be charged for care but may be eligible for grant support. I also give permission for dental providers to return to recheck dental sealants. By signing below, I acknowledge that I have read and understand this authorization as it pertains to me or a child in my care and have read and understand the HIPPA policy regarding myself or a child in my care.

Printed Name: _____ Signature: _____ Date: _____

