Dental connections
Smile Squad
1111 Ninth Street Suite 190, Des Moines
Phone 515.244.9136 x 124 Fax 515.244.9153

Main Dental Clinic
1111 Ninth Street Suite 190, Des Moines
Phone 515.242.9136 Fax 515.242.9153

SMILE SQUAD

PERMISSION TO RECEIVE DENTAL SERVICES THROUGH THE SMILE SQUAD MOBILE DENTISTRY PROGRAM

☐ **YES! My child may receive dental services** *(if yes, complete the rest of this form)*

☐ **NO, I do not want my child to receive dental services** *(if "no," do not complete this form.)*

STUDENT INFORMATION:

Student's Name: _____ **DOB:** _____ **Student's SSN:** _____

School: _____ **Teacher:** _____ **Grade:** ____ ☐ **Male** ☐ **Female** ☐ **Other**

Student's race/ethnicity: ☐ White ☐ Black/African American ☐ Native American ☐ Hispanic-Latino ☐ Asian ☐ Other

Parent Name: _____ **Parent Cell Phone:** _____

Address: _____ **City/Zip:** _____

Parent E-mail (required) :_____

INSURANCE INFORMATION *(Please select one):*

☐ Student has Medicaid # _____ or Hawk-I # _____

☐ Student does not have dental insurance **(SEE CHARITY CARE POLICY PG 2)**

☐ Student has dental insurance through a parent:

Name of Dental Insurance Company: _____

Policy Holder Name: _____ Policy Holder SSN: _____

Policy Holder DOB: _____ Policy Holder's Employer: _____

MEDICAL HISTORY:

Child's Dentist: _____ Dentist Phone: _____

Child's Medical Provider: _____ Medical Provider Phone: _____

1. When was your child's last dental exam? ☐ Never ☐ 3-6 months ago ☐ 6-12 months ago ☐ 12+ months ago

2. Has your child been treated for any of the following? **Please check any YES answers**

☐ **NONE**	☐ Asthma	☐ Seizures	☐ Epilepsy	☐ Kidney problems	☐ High blood pressure
☐ Anemia	☐ Diabetes	☐ Heart murmur	☐ Heart defect	☐ Liver problems	☐ Tuberculosis (TB)
☐ ADD/ADHD	☐ HIV/AIDS	☐ Cancer	☐ Tonsilitis	☐ Infectious Hepatitis	☐ Behavioral concerns

3. Has your child ever had a serious illness not listed above? ☐ No ☐ Yes (explain) _____

4. Does your child need medicine before dental treatment because of heart or other medical conditions? ☐ No ☐ Yes

5. Is your child allergic to any of the following? ☐ **NONE** ☐ Anesthetics ☐ Sulfa ☐ Latex ☐ Penicillin/Amoxicillin ☐ other _____

6. Is your child under the care of a doctor now? ☐ No ☐ Yes why? _____

7. Please list any daily medications your child takes? ☐ No ☐ Yes list _____

8. Has your child ever had a head or mouth injury? ☐ No ☐ Yes explain _____

SERVICES:

- **Examination, cleaning, X-rays, fluoride**
- **Sealants**: a protective coating applied to the chewing surface of molars to help prevent cavities
- **Fillings**: removes decay from the tooth and fills the hole with a solid material. Anesthetic used if necessary.
- **Pulpotomy**: similar to a root canal, medication is placed on the nerve of the tooth to help the tooth heal. Anesthetic used if necessary.
- **Silver crowns (baby teeth):** placed on teeth with large cavities and remain until the tooth comes out. Anesthetic used if necessary.
- **Extraction (baby teeth):** necessary when the cavity is too big for a filling, when the tooth is infected, or when a tooth will not come out on its own. Anesthetic used if necessary.

PLEASE READ AND SIGN

INSURANCE AND PAYMENT:

- If you have insurance, your signature on this form authorizes Dental Connections to bill claims for services rendered. Please be aware this will affect your child's benefits. Dental Connections is not responsible for any cost incurred from your child's dentist if services affect your child's frequencies or benefits.
- You are responsible for payment of any copay, deductible, or other cost-sharing amount required by your insurance plan. If your child does not have dental insurance, you are responsible for payment of the services
- Dental Connections will send an invoice to the email or physical address provided after the insurance claim is processed.
- If you do not provide your child's dental insurance information, we will collect insurance information available to us.

DENTAL CONNECTIONS CHARITY CARE POLICY

Dental Connections is committed to providing dental care regardless of a patient's ability to pay. If you are unable to afford the cost of services, fill out the questionnaire below to see if your child qualifies for free or discounted services under **Dental Connections' Charity Care Policy. Filling out this information does not guarantee your child will qualify for discounted services under Dental Connections' Charity Care Policy. If you apply and are not eligible, Dental Connections will NOT provide services to your child without further consent.**

1. **Name of parent(s) living in the household:** _____
2. **What is your monthly household income? $**_____
3. **Are any adults in the household unemployed?** ☐ Yes ☐ No
4. **How many children or other dependents live in the Household?** _____

AUTHORIZATION AND RELEASE:

By signing this form, I authorize Dental Connections to provide any dental treatment listed in the "services" section to my child as deemed necessary by the dentist or hygienist. I authorize payment of insurance benefits directly to Dental Connections. I certify that the information provided by me is accurate to the best of my knowledge. For services provided on the mobile units, I understand some services may be provided by a dental hygienist or a dental student because of limited access to dental services in the community and these services do not take place of regular dental care in a dental office. I authorize the sharing of information regarding my child between the Dental Connections and my child's school. I authorize Dental Connections to obtain medical information from my child's primary health care provider as it pertains to his/her oral health. I understand my child may be photographed while participating with this program and the purpose of such photographs is for clinical documentation and/or promotion of the Smile Squad Program.

I understand that receiving dental care on the Mobile Dental Clinic does include possible risk of injury, harm, and loss. I hereby acknowledge the risks and release and forever discharge Dental Connections (including the Smile Squad) as well as all its past, present, and future affiliates, successors, assigns, employees, volunteers, vendors, partners, directors, and officers (collectively, the "Released parties") for any claim whatsoever which arises or may arise on account of any treatment or service rendered in connection with my child's dental care. **I agree that my signature gives full release of liability to the released parties to the fullest extent permitted by law.**

NOTICE OF PRIVACY PRACTICES:

I understand the Notice of Privacy Practices of Dental Connections, Inc. is available upon request and is also accessible on the Dental Connections website. I have had full opportunity to read the Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to the Dental Connections to use and disclose mine or my child's protected health information to carry out treatment, payment activities, and healthcare operations. I understand that I have the right to revoke this consent at any time by giving written notice and that my revocation could result in the discontinuation of treatment by Dental Connections. I further understand that Dental Connections reserves the right to change the Notice of Privacy Practices as they have been described. If the Notice of Privacy Practices is revised, I will be issued the new Notice of Privacy Practices that contains the changes. Those changes may apply to any of my protected health information.

CONSENT TO RECEIVE ELECTRONIC COMMUNICATIONS

By checking the box and signing below, I consent to receive communications via email or text which may contain protected health information. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing Dental Connections with an update to my email address as necessary. I can withdraw my consent to electronic communications by calling 515-244-9136.

☐ **I consent to Dental Connections communicating with me electronically via email or text message.**

By signing below, I certify that the information I have provided is true and accurate to the best of my knowledge.

SIGN HERE Signature of parent: _____ Date: _____