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## **Smile, It's Healthy! and Raytown Public Schools are pleased to announce that a Smile, It's Healthy! mobile dentist office will be coming to your child's school!**

Smile, It's Healthy! is a dental services organization focused on bringing top-notch dental services to underserved members of our community. We provide our dental care to patients by eliminating the need to travel to the dentist – we come to you! We believe this is an excellent way to make sure all of our students have access to preventative and restorative dental care!

Let us show you what we offer!

Smile, It's Healthy! was founded with a mission to ensure that each kid has access to the dental services they deserve. We will be providing on-site dental services this school year, which includes:

- X-rays
- Exam by a licensed dentist
- Teeth cleaning and educational session
- Fluoride varnish application
- Sealants, as needed
- Restorative treatment, as needed

Smile, It's Healthy! accepts Medicaid, all private dental insurance, cash pay, and we also offer a grant program for students with financial hardship.

Smile, It's Healthy! will be visiting your child's school twice a year, to ensure our students are getting dental care every 6 months, as recommended by the American Dental Association.

**We look forward to seeing your child soon!**

### **Consent and Authorization Information**

**Consent for Treatment.** By my signature below, as the custodial parent/legal guardian of the child named above, I authorize Smile, It's Healthy!'s affiliated dentists, hygienists, and assistants to provide the following dental treatment to my child: dental exam, oral hygiene instruction, teeth cleaning, fluoride varnish, x-rays, dental sealants, cavity fillings, crowns, simple extractions, and pulpotomy. I understand that these dental services are provided by SIH MOKAN, P.A. contracted dental team. Unless I have made pre-arrangements to attend, and am there at the time of service, services will be provided without my presence. I acknowledge that, as the custodial parent/legal guardian of the child, I have been advised to arrange for continued dental care of my child, if necessary. I may at any time decline specific recommendations.

**Authorization to Disclose Child's Dental Records/Health Information.** By my signature below, as the custodial parent/legal guardian of the child named above, I authorize Smile, It's Healthy! and Friendly Dentist to use and/or disclose my child's dental records/health information to my child's school/organization and my child's school nurse/school representative to assist my child in getting follow-up dental care and/or to track school/organization health service utilization and ensure compliance with current school/organization guidelines.

**Release of Dental Records/Health Information for Payment/Assignment of Insurance Benefits.** By my signature below, as the custodial parent/legal guardian of the child named above, I authorize Smile, It's Healthy! and/or Friendly Dentist to release my child's dental records/health information which may be requested to process claims for payment of medical and/or dental services to third party payors responsible for payment of my child's charges including, but not limited to, insurance companies, health benefit plans, prepaid medical plans, government agencies, or intermediaries representing any of the above. I authorize that payment be made to Smile, It's Healthy! or Friendly Dentist for any bills for service rendered to my child by Friendly Dentist. I understand that treatment by the Friendly Dentist may affect future benefits that my child may receive under private insurance, Medicaid, or CHIP.

**Consent to Release Information to Referred Dental Care Provider.** Communication between Smile, It's Healthy!, it's Friendly Dentists, and its referral network of restorative dental partners is important to help ensure that your child receives comprehensive and quality care. In the event restorative dental services are needed (i.e., anything beyond Smile, It's Healthy!'s scope of dental services), it may be determined by Friendly Dentist to refer your child to a member of our third party restorative dental care provider network (which includes providers accepting Medicaid and CHIP in geographically-friendly locations). This requires the disclosure of your child's dental record/health information, including diagnosis, treatment plan, progress, and medication if necessary. By my signature below, as the custodial parent/legal guardian of the child named above, I authorize the release of information related to my child's dental services and treatment to a member of Smile, It's Healthy!'s third party restorative dental care providers for the purpose of my child receiving follow-up dental and medical care.



(\* Indicates REQUIRED fields - we can not treat your child without this information.

**PARENT/GUARDIAN SIGNATURE REQUIRED FOR SERVICES\***

**YES, SIGN US UP!** I am a custodial parent or legal guardian of the child named below. I have read and understand the below dental services to be provided to my child by the Smile, It's Healthy! mobile dentist office and SIH MOKAN, P.A. dentists on-site at my child's school/organization and I voluntarily CONSENT to have my child receive the dental services to include dental exam, oral hygiene instruction, teeth cleaning, fluoride varnish, x-rays, dental sealants, cavity fillings, crowns, simple extractions, space maintainers, and pulpotomy and authorize the use and disclosure of my child's dental records/health information as set forth below. I have read the important notices and consents on the first page and understand and agree to the terms. This signed consent authorizes my child's initial and future dental visits for the period of one (1) year from the date signed below. I may withdraw this consent at any time by contacting Smile, It's Healthy! and/or the school/organization.



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**STUDENT INFORMATION REQUIRED FOR SERVICES**

\*Child's Legal First and Last Name: \_\_\_\_\_ \*Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*Gender (circle one): M / F Ethnicity: African-American / Latino / Asian / Caucasian / Other \* Social Security #: \_\_\_\_\_

\*Child's School: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Last Dental Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Parent's Legal First and Last Name (Printed): \_\_\_\_\_

\*Parent/Guardian Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*Parent/Guardian Email: \_\_\_\_\_

**\*CHILD'S DENTAL INSURANCE (Please select appropriate coverage and provide ALL requested information):**

<input type="checkbox"/> Medicaid
*Medicaid Plan Name: _____
*Medicaid ID #: _____
<b>You <u>must</u> provide medicaid ID # <u>OR</u> child's SSN in order for us to verify dental coverage and provide services.</b>

We are not currently in-network with any private or commercial dental insurance. If your child has private dental insurance and you're interested in us providing dental services, you can choose our cash pay option and are welcome to file your insurance yourself, we would be happy to provide.

**\*IF YOUR CHILD HAS NO DENTAL INSURANCE: (Please select an appropriate option below, if no insurance)**

- I agree to pay the reduced fee of \$75 for a comprehensive dental exam, dental cleaning, fluoride varnish, and x-rays.
- I request an application for grant paid services to be provided to my child. (If you select this option, we will send you a financial hardship application. Grant paid services are available only once per school year for preventative services only.)

**\*Medical History (circle YES or NO)**

Asthma/Breathing Problems YES/NO	Diabetes YES/NO
Heart Problems/Valve Replacements/Shunts YES/NO	Allergies: _____
Epilepsy/Seizures YES/NO	Current Medications _____
Bleeding Disorders YES/NO	Antibiotic Premedication Required for Dental Services? YES/NO
Other (please specify): _____	

I confirm that the above health information is accurate to the best of my knowledge.

**Detail Messages Authorization.** By completing the fields below, I authorize Smile, It's Healthy! and/or Friendly Dentists and their staff to leave a message on an answering machine, voicemail, or with a specified individual information regarding my child's scheduling, treatment, treatment results, referrals, or other information ("Medical Information"), as necessary. I have specified what information may be left and with whom. **(Complete all that apply).**

\*It is permissible to **contact me with Medical Information at the locations** checked below (check all that apply):

- Telephone Number:
- Email Address:

\*It is permissible to **leave voice messages** with Medical Information at the locations checked below (please fill all that apply):

- Telephone Number:
- Email Address:

\*My preferences for **automated appointment reminders** is (please fill all that apply):

- Telephone Number:
- Email Address:
- None – I do not wish to get automated reminders