Dental ACCESS Carolina, LLC

Dear Parent/Guardian:

We are pleased to inform you that we will **continue the dental program** at your child's school this year. As you know, Dental Access Carolina, LLC has equipped a van with everything necessary to provide complete general dental services on site at the school.

A **doctor** will be on site at the school on the days scheduled on a regular basis and will be working with students who have Medicaid or Private Insurance. The doctor, based on your child's needs, will determine the services rendered. They will include complete dental examinations, x-rays, cleanings, and fillings—all done **at school during school hours!!!**

If your child is enrolled in the Medicaid program or is covered by Private Insurance and you would like your child to participate in this program, please fill out **BOTH SIDES** of the attached form, **sign it**, and return it to your child's teacher **tomorrow**. Be sure that you fill in your child's **correct social security number, birthdate, and 10-digit Medicaid number or insurance information** in the spaces provided on the front of the form. The dentist cannot see your child unless this information is provided and the form is **signed on the back**. During the course of the school year, services will be rendered as deemed necessary by the doctor and you will receive notification of treatment rendered after each visit.

If your child **has been seen by us before at school** and you would like for us **to continue** as your child's dentist, please **complete** the information at **the bottom** of this letter, **sign it**, and return it to your child's teacher **tomorrow**.

(Please do not detach)

Child's Full Name _____ Grade _____ Teacher _____

Social Security Number _____ - _____ - _____ Birthdate _____ / _____ / _____

SC Medicaid # _____ (Include **ALL 10 Digits**)

OR

Insurance Company _____ Phone _____

Subscriber name _____ Subscriber ID # _____

Employer _____ Group Name _____ Group # _____

Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child

Parent or Guardian Name _____ Phone _____

Emergency Contact _____ Phone _____

Please list any changes in your child's medical history (medications, surgeries, hospitalizations, allergies).
Use back of page if necessary. _____

I certify that the above information is correct and complete to the best of my knowledge. I give consent for Dental Access Carolina, LLC to provide dental care and treatment for the child listed above and I certify that I am authorized to give such consent. I hereby authorize release of any information that will assist in treatment or in processing of claims for services rendered. I understand that photographs may be taken for educational or documentation purposes and give consent. Since filling out the original, complete Medical History Questionnaire, there have been no changes in the medical history of the child listed above unless noted above. Dental Access Carolina, LLC is authorized to rely on said medical history form until notified of any change.

Signature of parent/guardian _____ Date _____