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:**_____ **Gender:**_____

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) 879-7755**

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**
- X-Rays and reports can be sent to the dental office of your choice.

As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus" at any time or in any place. Be assured that we have always followed state & federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance you could be exposed to an illness, just as you might at your own gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between patiens, dentist, and staff.

I (parent/Legal Guardian) give Dentist R US/Healthy Smiles permission to perform an initial exam, cleaning, flouride, sealants, necessary X-Rays, and a 6-month check-up (cleaning, fluoride, sealants) on my child; I understand that these services may 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 deductables 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 third-party provider of dental benefit. I have received and reviewed Notice of Privacy Practice (HIPPA), on our website DentistRUs.com. 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 unsterdand the above information to the best of my knowledge. The undersigned agrees that the dental provider may release data as necessary for the purpose of public health activities and reporting to the MDHHS Oral Health Program (OHP).

PARENT/ GUARDIAN SIGNATURE (REQUIRED) _____ **Date:** _____

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

For office use only

"Smile Savers"

DENTISTS R US _____

NAME_____ **DATE:** _____

EXAM _____

PA 161 EXAM _____

PROPHY _____

FLUORIDE TREATMENT _____

BITEWING X-RAYS 1 / 2 / unable (please circle)

PERIAPICAL X-RAYS 1 / 2 / unable (please circle)

EXISTING SEALANTS _____

SEALANTS PLACED 3, 14, 19, 30
2, 15, 18, 31

REASON SEALANTS WERE NOT PLACED:

_____

DOCTOR: _____

HYGIENIST: _____

ASSISTANT: _____

EXISTING FILLINGS _____

_____

EXISTING CROWNS: _____

_____

CAVITIES _____

WATCH: _____

ABSCESS: _____

EXTRACTION: _____

INTRA ORAL EXAM

Soft tissue_____

Gingiva_____

Occlusion_____

Palate_____

Lips_____

EXTRA ORAL EXAM

Bruises or Swellings_____

TMJ_____

ORTHO CONSULT Y / N

_____

Performed general scaling with hand instruments, checked with explorer, and flossed all contacts. Proper technique of brushing and flossing with fingers demonstrated. Patient given a soft toothbrush.

NOTES:_____

DATE: _____

EXAM _____

PA 161 EXAM _____

PROPHY _____

FLUORIDE TREATMENT _____

BITEWING X-RAYS 1 / 2 / unable (please circle)

PERIAPICAL X-RAYS 1 / 2 / unable (please circle)

EXISTING SEALANTS _____

RE-SEALED 3, 14, 19, 30
2, 15, 18, 31

SEALANTS PLACED 3, 14, 19, 30
2, 15, 18, 31

REASON SEALANTS WERE NOT PLACED:

_____

DOCTOR: _____

HYGIENIST: _____

ASSISTANT: _____

EXISTING FILLINGS _____

_____

EXISTING CROWNS: _____

_____

CAVITIES _____

WATCH: _____

ABSCESS: _____

EXTRACTION: _____

INTRA ORAL EXAM

Soft tissue_____

Gingiva_____

Occlusion_____

Palate_____

Lips_____

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Bruises or Swellings_____

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ORTHO CONSULT Y / N

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