UNIVERSAL SMILES… "*giving all kids a smile*"

DENTAL CONSENT FORM

Universal Smiles has partnered with your child's school to provide on-site dental services. The dental team, headed by a licensed dentist will provide the following services, as indicated: **dental exam/screening, dental cleaning, fluoride treatment and sealants (if needed)**. Sealants are a protective plastic coating placed on the chewing surfaces of the permanent back teeth that do not appear to be decayed. **NO needles or anesthetic is ever used**. This program does not offer restorative services (fillings) or removal of teeth. You will be contacted if your child requires any additional services. We encourage you to participate, especially if your child does not have a regular dentist. Let's enhance the oral health of your child!

Student's Name: _____ Date of Birth: _____ Male ___ Female _____

School Name: _____ Grade _____

Parent/Guardian Name: _____ Phone # _____

Address: _____

City Zip code

MEDICAID ID #: _____PLAN NAME: _____ SS# _____

If your child is covered by Private Dental Insurance please supply the following:

Name of Private Dental Insurance: _____ Ins. Phone# _____

Name of the Insured: _____ DOB: _____

SS# or ID# of Person Insured: _____ Group#:_____

Employer's Name: _____

MEDICAL INFORMATION:

Has your child had any history of, or any conditions listed below? YES / NO (IF YES CIRCLE CONDITION)

Diabetes	Seizures	Currently has a heart murmur	Asthma	Anemia	Cancer
Hepatitis	Rheumatic Fever	Heart Disease	Blood Disease	Hearing	Epilepsy	Thyroid

- Is your child taking any medication? If YES, please list:_____
- Does your child have any allergies? If Yes, please list:_____
- Any other medical related conditions? If yes please list:_____
- Has your child ever suffered injuries to the mouth, head or teeth? YES / NO

As the parent or guardian of the above named child or ward, I consent for my child to participate in the dental program and the receiving of Quality assurance exams. I authorize the provider dentist to use my child's or ward's insurance, Medicaid or ALL KIDS number for billing purpose only. This consent is valid for 12months. I understand that if I fail to sign this form my child will not receive dental services under this program.

PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____

MEDICAL HISTORY REVIEWED BY: _____ DATE: _____

We may take pictures of the students' smiles for use on our literature and internet site. Do you consent? Yes___ No____

NOTICE OF PRIVACY PRACTICES: OUR PRIVACY POLICY IS AVAILABLE ON OUR WEBSITE: WWW.UNIVERSALSMILES.BIZ

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