



Smile Texas / Mobile Dentists

Please return this form to your child's teacher in the next 2 days

- ☺ **Signature required.** Signed consent includes **initial visit** and **6-month check-ups** when appropriate. Optional restorative visit, if available.
- ☺ Preventive treatment includes exams, cleanings, fluoride, radiographs, sealants and referral when necessary.
- ☺ Restorative treatment is optionally available and may include, but is not limited to, fillings, pulpomies and simple extractions.

General and Health Information PLEASE PRINT CLEARLY IN INK

School or Program Name: _____ County: _____

Teacher: _____ /Grade: _____ /Child attends: M T W TH F (circle) AM PM

Child's Legal Name: _____

Child's Date of Birth: _____ Child's Sex: M F Last Dental Visit: _____

Your child's Social Security number: _____

Parent/Guardian Name: _____ Cell or Phone: (____) _____

Address: _____ City/Zip: _____

Relationship to child: _____ E-MAIL: _____

Has your child had any history of, or conditions related to, any of the following: Explain below. **NONE**

Asthma	Y N	Latex allergy	Y N	Heart Valve Replacement	Y N	Shunts or artificial joints	Y N
Hemophilia	Y N	Diabetes	Y N	Heart murmur (not requiring pre-medication)	Y N	Other	Y N
Blood disorder	Y N	Allergies	Y N	Heart murmur (requiring pre-medication)	Y N		Y N
Dental problems - explain below	Y N	Hepatitis	Y N	HIV/AIDS	Y N		

*** IMPORTANT:** List all medications, health history, medical and dental conditions below. *Attach another page if more space is needed.* **PLEASE INFORM US AT THE 6-MONTH VISIT IF THERE IS ANY CHANGE IN MEDICAL & DENTAL CONDITION BY FILLING OUT A NEW PERMISSION FORM.**

Medicaid/CHIP

We accept Medicaid, CHIP and most private insurance. They will cover your child 100%.

Child's 9-digit Medicaid Recipient ID Number:

Name of Private Dental Insurance Company (other than Medicaid): _____ Ins. Phone: _____

Group number: _____ Employer name: _____ Co. Phone: _____

Name of person under whom child is covered: _____ BIRTH DATE of Insured Adult: _____

Social Security number of insured adult: _____ Contract / ID number: _____

Secondary insurance information: Insurance Name: _____ Policy Holder: _____ Date of Birth: _____
ID Number: _____ Employer Phone: _____ Insurance Co. Phone #: _____

No Medicaid or Dental Insurance Only Check ONE Box

- I am able to pay the full fee for a dental cleaning, screening & fluoride per visit.
Ages 13 or younger: **\$88.00** Ages 14 or older: **\$107.00**
Please make check or money order payable to **Smile Texas/Mobile Dentists** & staple to this form.
- I need to pay for a subsidized service because I am unable to pay full fee.
It will cover dental cleaning, screening & fluoride.
Ages 13 or younger: **\$53.00** Ages 14 or older: **\$71.00**
Please make check or money order payable to **Smile Texas/Mobile Dentists** & staple to this form.
- Check here if you need financial aid for insurance co-pays/ deductibles if any. Most insurance covers prevention 100%.
- Check here if you have NO dental insurance **AND** you need full financial assistance for cleaning, screening & fluoride (grants unavailable for restorative care). We will mail you a grant application. Grants are available only once per year.

IMPORTANT: Parent/Guardian Signature Required

I am a custodial parent or legal guardian of the minor child named above. I understand that I am encouraged to attend this child's treatment. In case I cannot do so, I authorize an adult school official to accompany this child at school during dental check-ups, exams and/or dental treatment (whether restorative and/or preventive) and continue to wait for my child while the check-up, treatment or other authorized service takes place. The authorized adult school official may be a school nurse, principal or administrative employee, or an adult named by one of them. Affixing your signature to either line below legally acknowledges acceptance of these terms and conditions.

① As custodial parent or legal guardian of the minor child named above, I authorize and consent to this (my) child receiving from Elliot P. Schlang, D.D.S. Texas, P.C. and its affiliated dentists the preventive dental treatment described above, and allow the school nurse/school representatives, the local public health department(s), and/or a dentist of my choosing to obtain the child's dental record and radiographs. I authorize and direct Elliot P. Schlang, D.D.S. Texas, P.C. to bill on my behalf or the child's behalf; and collect payment from any insurance or other third party payer that covers the services provided to this child. I have had an opportunity to ask any questions about treatment my child may receive. I acknowledge receiving a notice of privacy practices today before signing. I understand that this child will receive the results of the dental exam on an Oral Health Report Card given to the child on the day of treatment. If I do not receive it or need another copy I will contact the toll free number listed below.

X SIGN HERE _____ Date: _____

(Parent/Guardian)

② **FILLING CAVITIES AND MORE** - after the prevention visit, the dentist may indicate the need for additional treatment. In some schools, Elliot P. Schlang, D.D.S. Texas, P.C. will be performing the follow-up restorative care. Sign your name below if you wish to grant permission for your child to receive the necessary additional restorative care at school, if available. Elliot P. Schlang, D.D.S. Texas, P.C. and its affiliated dentists will deliver restorative care, which can include, but is not limited to fillings, pulpomies, simple extractions and local anesthesia to numb for the patient's comfort, if necessary. I further authorize, Elliot P. Schlang, D.D.S. Texas, P.C. to bill on my behalf or the child's behalf and collect payment from any insurance or other third party payer that covers the services provided to this child. I understand that in some cases the dental treatment may not be able to be finished at school due to complexity or time restraints. If necessary, a referral will be made to the address and/or phone number of record on this application form. My signature set forth immediately below authorizes consent to all terms, conditions and acknowledgements set forth in paragraphs ① and ② covering both preventive and restorative dental care.

X SIGN HERE _____ Date: _____

(Parent/Guardian)

If the child has a dentist, you may wish to continue dental services with that provider. To avoid dental service or benefit duplication, please inform your dentist which services were performed at school (see oral health report card, provided after school dental visit, which will indicate services provided). Radiographs are taken & sealants applied at dentist's discretion. In cases where additional dental care is required for restorative and/or other dental needs, the parent/guardian must follow up with a dentist of their own choosing.