



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

<input type="checkbox"/> My child has MEDICAID/MI CHILD (covers 100% of cost) Medicaid ID Number: <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> Social Security Number (for billing purposes only): _____									<input type="checkbox"/> 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 _____ <i>Please note: HMO policies are not accepted</i>

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 patients, dentist, and staff.

I (parent/Legal Guardian) give Dentist R US/Healthy Smiles permission to perform an initial exam, cleaning, fluoride, 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 deductibles 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 understood 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 _____