

INSURANCE INFORMATION

You do not need to have insurance to participate.

If you have insurance, it will be billed directly. Parents will not be billed for dental services regardless of insurance status.

Your child may continue to receive services from your own dentist. However, services provided by Smart Smiles may affect insurance coverage for other dental visits.

MassHealth

MassHealth RID Number

___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/___

Delta Dental, CMSP or Other Dental Insurance

Dental Insurance Company Name

Subscriber's Name (First, Middle Initial, Last)

Subscriber's Address City State Zip

___/___/___ - ___/___/___ - ___/___/___/___

Subscriber's Date of Birth (*month / day / year*)

___/___/___ - ___/___/___ - ___/___/___/___

Subscriber's Place of Employment

Group Policy Number

(___ ___) - ___ - ___ - ___ - ___ - ___ - ___ - ___

Insurance Company Telephone #

Insurance Company Address

TREATMENT DETAILS

The dental program is available to all students

Services are provided **at your child's school** by Massachusetts licensed dentists, hygienists, and certified dental assistants. In some cases, dental students may accompany the dental professionals to provide educational and preventive services.

All students will receive an oral health screening, a fluoride treatment, and oral hygiene instruction by the dental provider.

Some Students will receive an exam, treatment plan, dental cleaning, dental sealants, restorations and x-rays as needed.

Some students may need to be scheduled for further dental treatment or specialty services and will be referred to a dental provider in your community.

Referrals are dependent upon the extent of the dental disease as well as the behavior of the patient.

Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning the patient's dental treatment. Most patients do not encounter any difficulties with their treatment. In rare instances, a patient may experience some discomfort or pain. If the patient indicates any resistance to the dental procedure, we will discontinue the treatment

The Tell-Show-Do technique is often used to gain the cooperation and confidence of the dental patient. The dental provider explains what they are going to do then shows what they are going to do with instruments on a model. The provider makes every effort to be a partner in care with the patient and family making the dental visit pleasant and informative.

CONTACT INFORMATION:

School-Based Program Coordinator
Boston Smart Smiles Program
(617) 638-6383



Great News!!!

Your child can receive the following
DENTAL SERVICES
at school:

- Dental Screening
- Dental Exam and Diagnosis
- Oral Hygiene Instruction
- Dental Cleaning
- Fluoride Treatments
- Dental Sealants
- Dental X-Rays
- Fillings and Restorative Dentistry

Partnering Agencies:

*Boston University Henry M. Goldman
School of Dental Medicine
Commonwealth Mobile Oral Health Services, LLC
DentaQuest Foundation
Forsyth Dental Hygiene Program at MCPHS
Tufts University School of Dental Medicine*

CONSENT TO PARTICIPATE

Please read, check one box, and sign below

- I understand that this consent will stay in effect for the current school year. If dental sealants are placed they will be rechecked and reapplied next year if needed.
- It is the parent/guardian's responsibility to inform the dental provider and/or the school nurse of any changes in their child's medical information
- I understand that a copy of my child's dental report will be given to the school nurse and that all information about my child will be kept confidential.
- If I have dental insurance, I authorize my insurance carrier to be billed for any services provided.
- I give permission for my child to have fillings with the use of local anesthesia, commonly called "novocaine."
- I have been given a copy of the Smart Smiles Notice of Privacy Practices.
- I understand that Smart Smiles may use my child's health information for treatment, payment, health care operations, and program evaluation.
- I have read and understand the dental program and I consent to have my child participate in Smart Smiles.

Please Check One Box

YES, I give permission for my child to participate in the Smart Smiles Dental Program.

NO, I do not give permission for my child to participate.

Name of Child

X

Signature of Parent or Legal Representative

Printed Name of Parent or Legal Representative

Relationship to the Child

Today's Date

PATIENT INFORMATION

Please be sure to complete all sections.

Child's First Name Last Name

School Name Grade Room Number

Address: Number Street Apt.

City State Zip

Child's Date of Birth (month / day / year)

Gender: Female _____ Male _____

Parent or Guardian Name

Best phone number to reach parent (home, cell, or work)

Another phone number for parent (home, cell, or work)

Parent email address

Has your child been to the dentist in the past year? yes ___ no ___ If **yes**, please write the date and reason for visit. _____

What language does parent speak? _____

What is your child's race?

- Asian Mixed
 American Indian/Alaska Native Other
 Black/African American White
 Hispanic
 Native Hawaiian/Pacific Islander

MEDICAL INFORMATION

Please be sure to complete all sections.

Does your child see a doctor for regular checkups?
yes ___ no ___

Physician's Name

Physician's Address

Physician's Phone

Does your child have **allergies**? yes ___ no ___
If **yes**, please check all that apply: Antibiotics,
Colophonium, Foods, Latex, Penicillin,
Resins, Medications (list) _____
Other: _____

Does your child need **antibiotics** before dental treatment? yes ___ no ___ If **yes**, please explain: _____

Does your child take **medications** on a routine basis? yes ___ no ___ If **yes**, please list: _____

Does your child have a **developmental disability**? yes ___ no ___ If **yes**, please explain: _____

Has your child ever had any of the following?

Please check YES or NO for each condition:

YES NO

- AIDS/ARC/HIV
 Birth Defects
 Cytomegalovirus
 Diabetes
 Fainting Spells
 Hepatitis
 Herpes
 Rheumatic Fever
 Tuberculosis
 Venereal Disease
 Other: _____

YES NO

- Asthma
 Blood Disorders
 Congenital Heart Disease
 Epilepsy/Seizures
 Heart Disease
 Heart Murmur
 High Blood Pressure
 Kidney Disorder
 Pins/Broken Bones
 Stomach/GI Disorder