Smiles on Wheels offers children's dental hygiene services at **no cost to you!**

- Dental screenings, cleanings and education
- Sealants
- Fluoride treatments

A referral note will be sent home after the visit explaining services provided and information to help find a dental home, if needed.

**Complete the attached consent form** to help your child have healthy teeth!

If you have dental insurance, it will be billed for the services provided. If you don’t have dental insurance, services will be provided at **no cost to you.**

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**Event Site:** Hematite Health Clinic  
**Event Date(s):** **May 30th - June 2nd**

(Please circle)  
**YES/NO** Smiles on Wheels has my permission to use photos of my child for educational or promotional purposes. Parent/Guardian Initials: ___

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"I know it's important to keep my son's teeth healthy, but it's hard for me to take off work to bring my son to the dentist. Smiles on Wheels came right to the school so my son could get sealants. I feel better knowing his teeth are protected."

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**Smiles on Wheels**  
Mobile Dental Hygiene Care  
501c3 non-profit  
[www.smilesonwheels.org](http://www.smilesonwheels.org)

**Questions?**  
Contact Smiles on Wheels  
Jackson: 517-740-7422  
Upper Peninsula: 906-221-2389  
smilesonwheels@hotmail.com
Smiles on Wheels Parent Consent Form
Dental Sealant & Fluoride Varnish Program

School: ________________________________ Grade: ____________ Teacher: ________________________________

Child's Legal Name: ________________________________ (First) ________________________________ (Middle) ________________________________ (Last)

Address: ________________________________ (Street) ________________________________ (City) ________________________________ (ZIP) Phone #: ________________________________

Date of Birth: __ / __ / ______ Age: ______ M or F (Circle One) Parent Email: ________________________________

Preferred Language (Check one): □ English □ Spanish □ Other (Please Specify): ________________________________

Which of the following describes your child (Check One or More): □ Black/African American □ White □ Hispanic/Latino □ Asian □ Arab American □ American Indian/Alaskan □ Native Hawaiian/Other Pacific Islander □ Other

Yes, I give my permission for my child to receive: Fluoride, varnish, oral screening, dental cleaning and sealants, if needed.

Yes, I give my permission for my child to receive: Oral screening and sealants only.

No, I do not give my permission for my child to receive treatment with Smiles on Wheels.

Printed Parent Name: ________________________________ Date: ___

Signed Parent Name: ________________________________

This consent will be valid for the 12-month period of this program.

(Please circle):
YES/NO 1) Is your child allergic to anything? If yes, what?

YES/NO 2) Is your child taking any medications? If yes, what?

YES/NO 3) Does your child have any medical conditions such as heart disease, asthma, hay fever, hepatitis, cancer, diabetes, or any other medical condition? If yes, what?

YES/NO 4) Does your child have learning or emotional impairments? If yes, what?

No payment is required from you for this program. However, Medicaid/Healthy Kids Dental/MICare and other dental insurance carriers will be billed to help cover the cost of this program. Please fill out insurance information.

Medicaid #: ________________________________ Name of Insurance: ________________________________

Insured Name: ________________________________ (First) ________________________________ (Last)

Date of Birth: __ / __ / ______ Group #: ________________________________

Policy or ID #: ________________________________ OR Insured SS #: ________________________________

Employer: ________________________________ Employer Phone #: ________________________________

Your child's personal information will be kept confidential and will not be shared with any person who is not directly involved in the care of your child as part of the Health Insurance Portability and Accountability Act (HIPAA).

Dental services may be obtained at the patient's dental home rather than with the mobile dental facility and obtaining duplicate services may affect insurance benefits that he or she receives from private insurance, a state or federal program, or other third-party provider of dental benefits.

FOR OFFICE USE ONLY

Date: _________ RDH: _______ AD/CH Prophy: _______ Varnish: _______ Screen: _______ # Teeth: _______ Fills: _______ Cavities: _______

SP Needs: _______ Urgent Care/Abscessed #: _______ SEAL #: NONE 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29

Notes: ________________________________

Date: _________ RDH: _______ AD/CH Prophy: _______ Varnish: _______ Screen: _______ # Teeth: _______ Fills: _______ Cavities: _______

SP Needs: _______ Urgent Care/Abscessed #: _______ SEAL #: NONE 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29

Notes: ________________________________

Sealant Retention Check:

Date: _________ RDH: _______ All Retained: _______ REPLACED #: 3 14 19 30 2 15 18 31 4 5 12 13 20 21 28 29