Miles of Smiles, Inc.

Must complete both sides of form

Patient's name_____Today's date_____
Patient's address_____City_____State_____Zip_____
Home phone_____School_____Teacher_____Lunchtime_____
Patient's date of birth_____ Age_____ Social Security #_____ Sex M F (circle one)
Child Medicaid # _____ Plan Information_____
Race (circle one) Caucasian American Indian African American Asian Hispanic Other_____
Emergency contact_____ Contact phone # _____
Physician name _____ Physician phone # _____
Language spoken in house_____

Parent/guardian name_____Relationship to patient_____
Parent/guardian date of birth _____ Social Security #_____E-mail_____
Parent/guardian address _____ City_____ State_____ Zip_____
Home phone_____ Work phone _____Place of employment_____

Health/Dental history

PLEASE CHECK any of the following that your child had or presently has:

⑨ Heart/Vascular Disease ⑨ Asthma ⑨ Kidney Disease ⑨ Cancer/Leukemia
⑨ Heart murmur → ⑨ pre-med required? ⑨ Diabetes ⑨ Epilepsy/Seizures
⑨ Anemia ⑨ Rheumatic Fever ⑨ Liver Disease ⑨ Bleeding Tendency
⑨ ADHD ⑨ Mental Disability ⑨ Physical Disability ⑨ Other _____

CHECK any of the following that your child is **ALLERGIC** to or has had an adverse reaction to:
⑨ Aspirin ⑨ Local anesthetic ⑨ Penicillin ⑨ Latex (balloons, gloves, rubber, etc.)
⑨ Erythromycin ⑨ Other _____

Is your child taking medications? ⑨ Yes ⑨ No
If yes, list medications and reason for taking _____
Has your child ever seen a dentist before? ⑨ Yes ⑨ No
If yes, who? _____ When? _____
Does your child have any dental pain now? ⑨ Yes ⑨ No
If yes, how long? ⑨ Days ⑨ Weeks ⑨ Months

I give my informed consent for the dentists and their auxiliary staff to take x-rays and photos of my child's mouth, face and teeth to provide the care the dentist deems necessary for the treatment of his/her oral condition. I will receive information advising me of my child's oral health needs.

I also authorize the release of information for any applicable insurance coverage.

Please check any procedure you would NOT like completed in our program:

⑨ Exam ⑨ Sealants ⑨ Extractions ⑨ X-rays ⑨ Fillings
⑨ Pulpotomies ⑨ Cleaning ⑨ Chrome crowns ⑨ Space maintainers
⑨ Fluoride application ⑨Nitrous Oxide also known as laughing gas (not used in schools, office use only)

_____ _____ _____ _____
Patient's signature or Parent or Guardian Date Dentist signature Date

We will be unable to see your child unless both sides of the form are completed and ***all three signature lines are signed (1 signature on front)*** *Please complete back of form* ***(2 additional signatures on back of form)***

Turn over →

Portable Dental Program 2015
Income Guidelines to receive services — 200% of Federal Poverty Level guidelines

You must provide your household income to be eligible for free dental care from Miles of Smiles, Inc.

List names of all household members	Gross monthly earnings (before deductions)	Monthly welfare, child support, alimony	Monthly payments from pensions, retirement, Social Security	Any other monthly income
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

2 Signature of Adult Household member _____

I certify that all of the above information is true and correct and current. I understand that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal Laws.

HIPPA Notice: (Attached sheet) or you can view it online at www.milesofsmilesinc.org/facts_and_forms

We are required by law to give you a copy of the HIPPA notice and to obtain your written acknowledgement that you have received a copy of this notice.

3 I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Signature of Parent/Legal Guardian/Patient's Representative

1 & 2 & 3 **Signature required**

***** We will be unable to see your child unless both sides of the form are completed and all 3 signature lines are signed. *****