

INSURANCE INFORMATION

You do not need to have insurance to participate.

If possible, please send a copy of your insurance cards.
The insurance company will be billed directly.
You will not be billed for dental services.

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 ID (SS # or ID#)

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 and hygienists. In some cases, dental students may accompany the dental professionals to provide educational, preventive and restorative services.

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

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

Referrals depend on 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 a few times, 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 Exam and Diagnosis
- Oral Hygiene Instruction
- Dental Cleaning
- Fluoride Treatments
- Dental Sealants
- Dental X-Rays
- Fillings and Restorative Dentistry
- Recall Visits (*Continuous Care*)

Partnering Agencies:

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

CONSENT TO PARTICIPATE

Please read, check one line, and sign below

- I have read and understand the dental program and I consent to have my child participate in Smart Smiles.
- I understand that this consent will stay in effect while my child attends this school, unless I withdraw my authorization.
- It is the parent/guardian's responsibility to inform the dental provider and/or the school nurse of any changes in the child's medical history and insurance information.
- I have been given a copy of the Smart Smile Notice of Privacy Practices.
- I understand that Smart Smiles may use the patient's health information for treatment, payment, health care operations, and program evaluation.
- I understand 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.

Please Check One Line

_____ **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

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.

School Name Grade Room Number

Child's First Name Last Name

Address: Number Street Apt.

City State Zip

_____/_____/ - ____/_____/ - ____/_____/____/____

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

_____/_____/____/ - ____/_____/____/ - ____/_____/____/____

Social Security Number

Gender: Female _____ Male _____

Parent or Guardian Name

Relationship to Child

_____/_____/____/ - ____/_____/____/ - ____/_____/____/____

Home Phone

_____/_____/____/ - ____/_____/____/ - ____/_____/____/____

Work or Cell Phone

Has your child been to the dentist in the past year? yes ___ no ___ If **yes**, for what reason?

Race: Please check all that apply

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Asian | <input type="checkbox"/> Mixed |
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Other |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> White |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander | |

MEDICAL INFORMATION

Please be sure to complete all sections.

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:

- | NO | YES | NO | YES |
|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> AIDS/ARC/HIV | <input type="checkbox"/> | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> Cytomegalovirus | <input type="checkbox"/> | <input type="checkbox"/> Congenital Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> Herpes | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> Pins/Broken Bones |
| <input type="checkbox"/> | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> Stomach/GI Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____ | | |