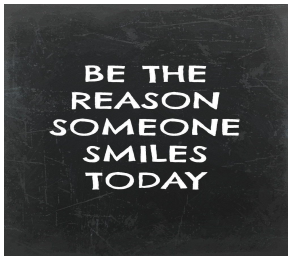
Smiles To Go

Dental Screening Consent Form

1620 East Main Street, Liberty, MS 39645
Office: 601-657-1164
Fax: 601-657-5936



School:_____

Student's Name: _____**Grade**:_____**Teacher**:_____

Our **Smiles To Go**, team, is so excited about coming to your child's school and providing preventive dental services (**exams, cleanings, sealants, x-rays, fluoride, etc**.). Life gets us so busy in the hustle and bustle, and it is difficult to catch up. It is our desire to help in this struggle, and bring dental care to your children. Our Dentists, Hygienists, and Dental Assistants are so passionate about helping not only the children but their families too. If you are interested in your child receiving these dental services at the school, then please complete this form and return it to the school. Once enrolled in our program, your child will remain in the program until they graduate to a new school or move. **If at any time you would like to remove your child, then simply call our office at 601-657-1164 and we will be glad to assist you.** Healthy children lead to healthy communities. Thanks for partnering with our team.

STUDENT INFORMATION: Male_____ Female_____ Birthdate: _____

Parent's Cell Phone #:_____ Backup Phone#:_____

Address:_____City_____State_____Zip_____

Email: _____

STUDENT INSURANCE: All children can receive these services

Child's Social Security Number:_____

MEDICAID/CHIP enrolled: _____YES _____NO Medicaid Number:_____

Other Insurance: _____Yes ____ No If yes, name of Insurance:_____

Policy Number:_____ Name of Subscriber: _____Employer: _____

Subscriber's Date of Birth: _____Subscriber's Social Security Number _____

HEALTH HISTORY: Has your child ever had any serious health problems listed below: (Please check)

____Diabetes ____Asthma____Behavior Problems _____Anemia_____Sickle Cell

____ Other (explain) _____ _____

Is your child allergic to any food, medication, latex, etc? If so please list_____

If your child is currently taking any medication please list:_____

Date of last dental visit: _____

Treatment provided may affect the future benefits that the patient receives under private insurance, Medicaid, or the Children's Health Insurance Program (CHIP). For example, if you choose to participate in our program then this will count as one of your regular dental visits, etc. It is not our desire to take children away from their regular dentist, we want to help the families who either can't afford dental care, can't take off of work, no vehicle, etc.

PARENT OR LEGAL GUARDIAN MUST READ AND SIGN BEFORE CHILD MAY PARTICIPATE

I give permission for Smiles To Go, LLC to treat my child and acknowledge that this form will become part of a permanent record that will be held in strict confidence. I verify that I have read this form and understand the privacy of health information (HIPAA). I also have read the back page and give permission for photo/video images of my child to be used.

Signature:_____ Please Print Name:_____ **Date:_____**

HIPAA: CONFIDENTIAL PROTECTED HEALTH INFORMATION

STG's Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your right under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how PHI about you is used or disclosed. By signing this form, you consent to our use and disclosure of your PHI for your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you.

The patient understands that:

- PHI may be disclosed or used for treatment, payment, or health care operations.
- STG has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- STG reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their PHI, but STG does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- STG may condition receipt of treatment upon the execution of this Consent
- The patient acknowledges that he/she has received a copy of our HIPAA practices.

PHOTO/VIDEO RELEASE FORM

By signing this consent form, I acknowledge that I am the legal guardian of the named student, and hereby grant permission to Smiles To Go (STG) and its employees the irrevocable and unrestricted rights to reproduce the photographs and/or video images taken of me, or members of my family, for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium. I hereby release STG and its legal representatives for all claims and liability relating to said images or videos. Furthermore, I grant permission to use my statements that were given during an interview or guest lecture with or without my name, for the purpose of advertising and publicity without restriction. I waive my right to any compensation.

____YES, I give permission for photos/videos to be taken of my child.

____NO, I do not give permission for photos/videos to be taken of my child.