



Smile New Jersey...the mobile dentists are coming to shine your smile!

Please return this form to your child's teacher in the next 2 days

- ☺ **Signature required.** Signed consent includes **initial visit** and **6-month check-ups** when appropriate.
- ☺ Treatment is limited to exams, cleanings, fluoride, radiographs, sealants and referral when necessary*. All professional services provided by New Jersey licensed dentists & hygienists; managed by Little Smiles New Jersey P.C.
- ☺ Insurance such as *Medicaid* and *NJ Family Care* cover your child **100%**.

General and Health Information

PLEASE PRINT CLEARLY IN INK

School or Program Name: _____ County: _____

Teacher: _____ Grade: _____ Room #: _____

Child's Legal Name: _____

Child's Date of Birth: _____ Child's Sex: M F Last Dental Visit: _____

Your child's Social Security number: _____

Parent/Guardian Name: _____ Cell or Phone: () _____

Address: _____ City/Zip: _____

Relationship to child: _____ E-MAIL: _____

Circle when child attends: M T W TH F AM / PM Full Day

Has your child had any history of, or conditions related to, any of the following:

- Asthma Blood disorder Diabetes Hepatitis Heart murmur (not requiring pre-medication) Shunts or artificial joints
- Hemophilia Latex allergy Allergies Heart valve replacement Heart murmur (requiring pre-medication) HIV/AIDS Other (describe)

*** IMPORTANT:** List all medications, health history & other problems below. *Attach another page if more space is needed.* **PLEASE INFORM US AT THE 6-MONTH VISIT IF THERE IS ANY CHANGE IN MEDICAL HISTORY BY FILLING OUT A NEW PERMISSION FORM.**

Medicaid/NJ Family Care

We accept Medicaid, NJ Family Care and most private insurance.

Child's 16-digit CCN Number: 7 7 7 [] [] [] [] [] [] [] [] [] [] [] [] [] [] [] []

Name of Private Dental Insurance Company (other than Medicaid): _____ Ins. Phone: _____

Group number: _____ Employer name: _____ Co. Phone: _____

Name of person under whom child is covered: _____ BIRTH DATE of Insured Adult: _____

Social Security number of insured adult: _____ Contract / ID number: _____

Secondary insurance information: Insurance Name: _____ Policy Holder: _____ Date of Birth: _____

ID Number: _____ Employer Phone: _____ Insurance Co. Phone #: _____

No Medicaid or Dental Insurance Only Check ONE Box

- I am able to pay the full fee for a dental cleaning, screening & fluoride per visit.
Ages 15 or younger: **\$94.00** Ages 16 or older: **\$118.00**
Please make check or money order payable to **Smile New Jersey** and staple to this form.
- I need to pay for a subsidized service because I am unable to pay full fee. It will cover dental cleaning, screening & fluoride.
Ages 15 or younger: **\$78.00** Ages 16 or older: **\$98.00**
Please make check or money order payable to **Smile New Jersey** and staple to this form.
- Check here if you need financial aid for insurance co-pays/deductibles if any. Most insurance covers prevention 100%.
- Check here if you have NO dental insurance **AND** you need full financial assistance for cleaning, screening & fluoride. We will mail you a grant application. Grants are available only once per year.

IMPORTANT: Parent/Guardian Signature Required

I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described, and allow the school nurse/school representatives, the local public health department(s), and/or a dentist of my choosing to obtain the child's dental record and radiographs. I authorize and direct Little Smiles New Jersey P.C. to bill on my behalf or the child's behalf; and collect payment from any insurance or other third party payer that covers the services provided to this child. I have had an opportunity to ask any questions about treatment my child may receive. I acknowledge receiving a notice of privacy practices today before signing. I understand that this child will receive the results of the dental exam on an Oral Health Report Card given to the child on the day of treatment. If I do not receive it or need another copy I will contact the toll free number listed below.*

X Sign Here _____ Date: _____

(Parent/Guardian)
If the child has a dentist, you may wish to continue dental services with that provider. To avoid dental service or benefit duplication, please inform your dentist which services were performed at school (see oral health report card, provided after school dental visit, which will indicate services provided).

* Radiographs are taken & sealants applied at dentist's discretion. In cases where additional dental care is required for restorative and/or other dental needs, the parent/guardian must follow up with a dentist of their own choosing.