South Carolina Dental Screening Associates, LLP

Mobile/On-Site School-Based Dental Program

*Please mail, fax, or give to school nurse

IF YOUR CHILD SEES AN OUTSIDE DENTIST REGULARLY- DO NOT COMPLETE THIS FORM - DISCARD

Patient Information

School Name:			Teacher's Name:	
Last Name:	First Name:	MI:	DOB:	Nickname:
Male ◯ Female ◯ Grade: Age:			Race/ Ethnicity:_____	
Siblings in school K-12:				
			Email:	
Cell Phone:		Social Security Number:		
Home Phone:		Other Number:		
Patient Address:		City:	State:	Zip:

Patient Medical Information

Do you have any allergies? If so, please list them	Do you have any health conditions or problems? If so, please list them _____	Taking any medications? If so, please list
◯Latex ◯Penicillin ◯Local anesthesia	◯ Abnormal Bleeding ◯ Heart condition or defect ◯ Diabetes ◯ Epilepsy, seizures or fainting spells	

Patient Insurance Information

Does the patient have dental insurance: Yes ◯ No ◯	Date of last dental visit: Over a year ◯ Less than 6 months ◯ Less than a year ◯		Subscribers DOB:	MI:
Subscribers Last Name:	Subscribers First Name:	Insurance Address:		
Name of Insurance:	Insurance ID #:	Group #:	Insurance Phone #:	

Agreement/ Disclosure

I request and authorize SC Dental Screening Associates (SCDSA) and SC Smiles Dental licensed dentists, dental hygienists and assistants to perform my child's dental preventative and restorative services in addition to any other necessary treatments the dentists deem appropriate. **Services may include dental exam, x-rays, dental screening, dental cleaning, fluoride, sealants, fillings, extractions, pulpotomy, stainless steel crowns and space maintainers and more**. Referrals to specialists will be made when needed. I understand that photos may be taken and used for educational and promotional purposes. I further understand that if my child is not enrolled in Medicaid, or private insurance, and not funded through SC Smiles Dental, I am financially responsible for services performed. **Your insurance company will be billed for services rendered**. I authorize payment of Medicaid or insurance benefits directly to SCDSA. I request and authorize release and full disclosure of any information contained on this form and or acquired in the course of treatments, payments, referral purposes, to all appropriate school personnel, SC ORS, third party payers, Medicaid and SC DHEC, as deemed necessary by SCDSA. I understand SCDSA and SC Smiles Dental Notice of Privacy Practices are viewable at www.scsmilesdental.org. By signing below, I certify that the following information has been read in full and understood by me. I grant permission for the above child to receive services outlined above.

Parent/ Guardian Print_____ Relationship to Patient_____

Parent/ Guardian Signature_____ Date_____

By signing and submitting this enrollment form you are consenting to school dental services, listed above.

Office Number: 843.957.0001 **2411 N. Oak St., #403-I, Myrtle Beach, SC 29577** **Fax:843.314.4224**

SC Smiles Dental: 843.492.7747 **Email:info@scsmilesdental.org** **Website:scsmilesdental.org**

South Carolina Dental Screening Associates, LLP

Mobile School-Based Dental Program

You Can Protect Your Child's Teeth!

By completing this form and returning it to your school nurse or to the address or fax number on bottom of this sheet you can help protect your child's teeth from tooth decay/cavities.

Who We Are:

South Carolina Dental Screening Associates (SCDSA) are licensed dentists, dental hygienists and assistants that go into schools and other facilities throughout SC to provide dental services to children ages 1-19.

Parents do not have to miss work and students do not have to leave school, so routine dental care is easily managed by our program. We provide dental services & oral health education at on-site locations as needed or when requested.

During your Child's School Day Our Licensed Dentists and Dental Hygienists Will Provide:

- Education for your Child on how to Prevent Tooth Decay & Maintain a Healthy Mouth
- Dental screening or exam, x-rays, dental cleaning and fluoride, and if needed; sealants. Sealants are thin plastic coatings that are painted in the grooves of the biting surfaces of permanent back molar teeth to help prevent and stop cavities from developing.

On site dentists will then provide, if needed, fillings, extractions, stainless steel crowns and space maintainers (With parental consent and based on Dentist availability and scheduling). Referrals to Specialists will be made when deemed necessary.

Costs?

If your child has Medicaid or SCHIP, we will bill them directly and there will be no cost to you. If you have dental insurance, we will submit the claim directly to your insurance (you must provide us with the insurance information). If you have financial hardship and no insurance you can apply for SC Smiles Dental funding to cover your services (free services ...based on available funding). Reduced rates and sliding scale rates for services are also available for families with varying financial needs.

A screening report will be sent home with your child on the day they receive services. The report will list services performed, the condition of the child's mouth and what services are needed.

Fill out form on the back page printing clearly in black ink. You must fully complete the form including all medical questions and sign at the bottom of form for your child to receive services.

*Classy Smiles / SC Smiles Dental is a non-profit which helps to provide free services to those who qualify.

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