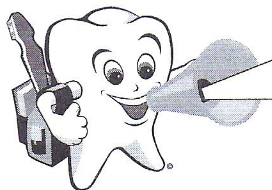
IN-SCHOOL PREVENTIVE DENTAL CARE AT NO COST TO YOU

Our school, in partnership with Smile New York Outreach, is offering every child **PREVENTIVE DENTAL CARE AT NO COST TO YOU**. A licensed dentist or dental hygienist will regularly check your child's mouth and teeth as well as provide a cleaning, fluoride treatment, apply sealants as needed, and may take x-rays. A dental report will be sent home with your child.



PROTECT YOUR CHILD'S TEETH

COMPLETE AND RETURN THE PERMISSION SLIP BELOW.

☑ **YES**, I would like my child to have **PREVENTIVE DENTAL CARE AT NO COST TO ME**.

Child's Name ______________________ Birth Date ____________ Male/Female _____

Address ______________________ City ____________ State _____ Zip ________

School ______________________ Teacher ______________________ Grade _______

Parent/Guardian Name ____

Email ______________________________ Phone ______________________

IMPORTANT HEALTH QUESTION

Does your child have any past or present medical or dental conditions or disabilities? This may include heart issues, breathing problems, brain/seizure disorders, allergies (including drug allergies), diabetes, bleeding problems, communicable diseases or immune disorders etc. If Yes, explain below (attach additional pages as needed). IF NO, LEAVE BLANK.

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☐ **MY CHILD HAS CHILDREN'S MEDICAID/CHILD HEALTH PLUS:** Affinity Health Plan, Amerigroup, HIP/Emblem, Healthfirst, Hudson Health Plan, Fidelis Care MetroPlus Health Plan, UnitedHeathCare, Wellcare

Enter Child's Children's Medicaid/ Child Health Plus ID Number: ______________________________

EXAMPLE A B 1 2 3 4 5 C

OR Child's Social Security # if Medicaid number is not available ☐☐☐ - ☐☐ - ☐☐☐☐

☐ **MY CHILD HAS PRIVATE DENTAL INSURANCE:**

Dental Ins. Company name (other than Medicaid) ______________________ Ins. Phone ____________

Group # ____________ Employer name ____________ Co. phone ____________

Name of Insured Adult ______________________ **BIRTH DATE of Insured Adult** ____________

Member ID/Policy # ______________________ Social Security # of insured adult ____________

I understand and authorize Smile New York Outreach LLC (Provider) and its affiliated dentists and dental hygienists to provide the services noted above for the named child for whom I am the custodial parent or legal guardian. THIS PERMISSION INCLUDES ALL FUTURE DENTAL VISITS. I have read the IMPORTANT HEALTH QUESTION above and will report any significant changes in my child's health to 855-481-8639. I have read the IMPORTANT NOTICE AND CONSENT ON THE BACK OF THIS PAGE and understand and agree to its terms

Parent/Guardian Signature ______________________________ Date __________