Upward Smiles. Delivered.
Mobile Dental Clinic Enrollment Consent
1-573-327-8010

☐ **I would like to enroll my child in the Mobile Dental Services Program (there are no charges to you for any services)**

Patient First Name: _____ **Last**: _____ **MI:** _____

Gender Identity: ☐ male ☐ female ☐ other **Date of Birth**: _____ **Date of Last Dental Exam**: _____

School: _____ **Teacher**: _____ **Grade**: _____

Parent/Guardian Name: _____ **Phone #:** _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Email: _____

Emergency Contact: _____ **Phone #:** _____

Child's Primary Physician: _____ **Phone #:** _____ ☐ **May contact**

☐ ADD/ADHD
☐ Artificial Joint
☐ Asthma
☐ Hospitalization in last 5 years
☐ Seasonal Allergy
☐ Latex Allergy
☐ Allergies (Other)
☐ Diabetes
☐ Fainting/Seizures
☐ Heart Condition
☐ Hearing, Speech, Communication problems
☐ HIV/AIDS
☐ Rheumatic Fever
☐ Hepatitis A, B, or C _____

☐ Check here if antibiotic pre-medication is required for dental treatment

If you checked any of the above, please explain: _____

My child is currently taking these medications: _____

Is there anything else we should know about your child? _____

Insurance Information: Please check appropriate box and fill in all requested information.

☐**Medicaid** _____ **8 digit MO Healthnet ID#** ___ ___ ___ ___ ___ ___ ___ ___

☐**Private Dental Insurance** ☐**Uninsured** **THERE IS NO CHARGE TO YOU FOR ANY TREATMENT RENDERED**

Please read carefully and sign if you agree to all terms. By signing this Health History & Consent form, you are giving consent to Upward Smiles, Inc. ("The Practice"), its licensed dental professionals, and dental auxiliaries to provide any dental services and/or treatment deemed necessary for your child.

I, as the parent or guardian of the above listed child, authorize The Practice or any individual designated by The Practice to act for me in any emergency, accident, or illness while my child is under their care.

I give consent for my child to receive dental services. *To the best of my knowledge, the medical history questions have been answered correctly and accurately. I release The Practice and its contractors, employees, agents, and affiliates from any liability that should arise from any mistakes or omissions on this form. I give consent for my child to receive local anesthetic (numbing of the teeth), preventative & restorative dental treatment (including , but not limited to, fillings, extractions, primary root canals, stainless steel crowns, sealants, cleaning and fluoride), and to be photographed while at the clinic.*

I authorize The Practice to bill Medicaid and receive payment for dental services performed, if my child has active coverage. I acknowledge that I am able to exercise my rights under HIPAA of 1996 to access The Practice's privacy policy by visiting their website at www.upwardsmiles.com/documents or by visiting any of The Practices' locations, and that all information shared here is confidential. I understand that my child's oral health results will be shared with the school nurse for the purposes of data collection and care coordination. I understand this consent is valid indefinitely from the date of signature, though The Practice might require me to complete a new consent form each year in order to keep my child's health history information accurate and up-to-date. If I wish to revoke this consent, I understand I can only do so in writing to The Practice.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____

(FOR YOUR CHILD'S SAFETY, YOU MUST PROVIDE A COPY OF YOUR DRIVER'S LICENSE OR OTHER GOVERNMENT ISSUED IDENTIFICATION WITH THIS FORM)