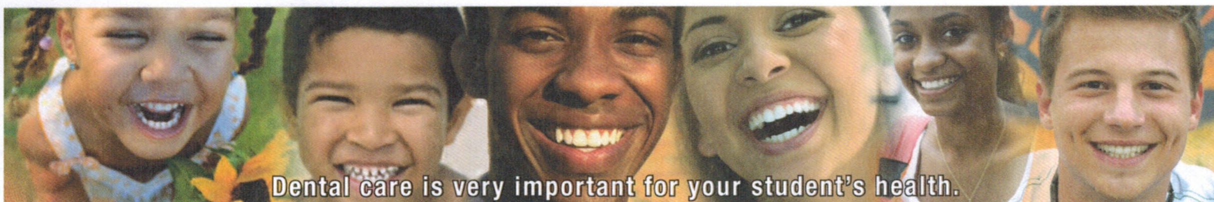
Help A Child Smile
Mobile Dental Program

Great News! The Help a Child Smile dental program has partnered with your child's school to offer full-service dental care at the school.



Easy & Convenient... Has your child visited another dentist within the last 12 months? If not, they can enroll.

IF YOUR CHILD ALREADY HAS A DENTIST YOU SHOULD KEEP GOING TO THAT DENTIST.

TOTAL DENTAL CARE	Our complete dental care includes an exam, x-rays, cleaning, fluoride, sealants, and cavity treatment when needed.

School: ______________________ County: ______________________

Student Name: ______________________ M___ F___ Student Date of Birth ___/___/______

Primary Phone: (____) ______________ Day Phone: (____) ______________ Cell Phone: (____) ______________

Address: ______________________ Apt#: ________ City: ______________ Zip: ________

Email: ______________________ Grade: ______ Teacher's Name: ______________________

☐ **CHILD HAS MEDICAID/PEACHCARE:**

Enter Child's 12 digit Medicaid Recipient ID Number HERE →

Medicaid & Peachcare cover 100% of treatment

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☐ **CHILD HAS PRIVATE INSURANCE:** Insurance Co. Name: ______________________ Phone # of Co.: ______________

Policy Holder's Name: ______________________ Policy Holder's DOB: ______________

Policy Holder's ID or SS # ______________________ Employer: ______________________

☐ **CHILD IS UNINSURED:** (Circle One) Check, Credit Card or Cash

CHILD'S MEDICAL HISTORY

CHECK EACH CONDITION THAT APPLIES TO YOUR CHILD

- ☐ Recent Dental Problems
- ☐ Allergy to Medications/Other
- ☐ Asthma or Wheezing
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Hemophilia/Bleeding Problems
- ☐ Pregnant
- ☐ Sickle Cell Anemia
- ☐ Epilepsy/Seizures
- ☐ Liver Problems/Hepatitis
- ☐ Kidney Problems
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Communicable Disease
- ☐ Wheel Chair Access
- ☐ Heart Condition (describe below)

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____

Notify us of any medical history. A thorough and complete medical and dental history is important for a proper dental examination and evaluation.

List allergies to medication/other: ______________________

Name/phone # of child's physician: ______________________ / ______________________

Use space below to provide additional details on your child's health, including current medical treatment, other significant past illnesses, alcohol & tobacco use (including smokeless). List current medications and premedication if needed for dental treatment.

READ AND SIGN BELOW

I understand and authorize Mark Shurett, DDS, PC (Provider) and its affiliated dentists to provide the following services for the above-named child for whom **I am the custodial parent or legal guardian**: dental exam & oral hygiene instruction, teeth cleaning, fluoride treatment, x-rays & dental sealants. I authorize the dentist to fill any cavities or to place a stainless steel crown over the tooth if needed. I authorize Provider to extract any problem baby teeth or provide a baby root canal (removal of the nerves inside the tooth) as needed. I understand that there are risks to dental treatment including swelling or pain that may occur from the injection of a local anesthetic or allergic reaction. (For additional information regarding the risks of treatment and treatment alternatives, please call the number below.) I authorize & direct Provider to bill & collect payment from any Medicaid, insurance, or other payer. If I have private dental insurance, I will be billed for & agree to pay any deductibles and/or co-pays. Unless I have made pre-arrangements to attend, and am there at the time of service, services will be provided without my presence. I have received the Notice of Privacy Practices attached to this form and consent to the release of my child's medical record information as described therein.

You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the land-line and/or mobile telephone numbers provided on this consent form.

This signed consent authorizes my child's initial dental visit and follow-up visits. I may withdraw this consent at any time in writing to the address below.

SIGN HERE ______________________ PRINT NAME ______________________ DATE ________

For your privacy, please fold & secure.

Mark Shurett, DDS, PC 1806 Overlake Dr., Conyers, GA 30013
Visit us at: hcsga.com Phone: (800) 770-0388 Fax: (855) 413-8142

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