MHS MOBILE DENTAL * DENTAL SCREENING CONSENT FORM

Office Address: 1904 Lakeland Dr., Suite C, Jackson, MS 39216
Office: 844-737-7331 * **Central Unit Director:** 601-270-3180 * **Fax:** 877-737-7331 * **Web:** www.mhsmobiledental.com

PLEASE COMPLETE & RETURN THIS FORM ON THE NEXT DAY OF SCHOOL

It is very important that children see a dentist on a regular basis to stay healthy and avoid toothaches, cavities, and other problems so that they are better prepared to learn. Your child will now have the opportunity to receive a **dental exam, cleaning, fluoride, sealants, and other dental services** through this school-based mobile dental outreach program. The mobile clinic will be setup at your child's school for 1 week during the school year. The consent form is effective for the entire school year. After your child's visit, he/she will receive a walk-out statement to bring home that lists services performed and any additional information. If you have questions, please call one of the numbers listed above or visit mhsdental.com. *A separate form is needed for each of your children.

* PATIENT INFORMATION

CHILD'S NAME_____ **CHILD'S BIRTH DATE**_____ **GRADE** _____

GENDER ____M ____F **PHONE**_____ **TEACHER** _____**SCHOOL**_____

ADDRESS_____ **CITY**_____ **ZIP**_____

* INSURANCE INFORMATION (CHECK ONE)

_____ **MEDICAID / MS CHIP / MS CAN** (***ID Number**_____)

_____ **PRIVATE DENTAL INSURANCE** (***Policy/ID Number** _____) & (***Group Number** _____)
Name of Insurance: _____
Subscriber Name: _____
Subscriber D.O.B.: _____ Subscriber SSN: _____

_____ **UNINSURED**

* HEALTH HISTORY/INFORMATION

- Has your child ever had any serious health problems listed below: (Please check all that apply)
  ___Diabetes ___Asthma ___Behavior Problems ___Anemia ___Sickle Cell
  ___Other (Explain) _____
- Is your child allergic to any food or medication? If so, please list _____
- Is your child currently taking any medications? If so, please list _____
- Is your child allergic to? ____ Latex ____ Acrylic/Plastic
- Does your child have any dental pain? ___Yes ___No If Yes, how long_____
- If your child is currently seeing a dentist, list their name: _____ Date of last dental visit: _____

PARENT or LEGAL GUARDIAN MUST SIGN & CHECK YES BEFORE CHILD CAN PARTICIPATE

By signing below & checking YES, the parent or legal guardian is authorizing a MS state licensed dentist with MHS Mobile Dental to provide my child a **dental exam, x-rays, cleaning, fluoride, sealants** at their school without my presence unless I withdraw consent. Dental care service is provided for children with Medicaid, CHIP, Private Insurance, or those with **no insurance** coverage**. Services are no out–of-pocket costs and are charged directly to Medicaid, MS CHIP, MS Can, or private insurance provider. If your child already sees a dentist on a regular basis, the parent or guardian should continue to arrange dental care through that provider. The treatment of your child through this mobile dental clinic may affect insurance benefits (as with any dental office) as treatment services will be billed to your dental insurance provider.** Three to Six months following this initial visit, MHS Mobile Dental in partnership with North Sunflower Medical Center may provide a basic follow-up screening.

- **CHECK ONE: _____ YES, I want my child to be treated by MHS Mobile Dental _____ NO, I decline this service**
- **PLEASE SIGN HERE: _____ DATE: _____**
- **PRINT PARENT or GUARDIAN NAME: _____ RELATION TO CHILD: _____**