PORTABLE SMILES MOBILE
313-682-5888

"NO COST TO YOU"

PORTABLE SMILES Mobile

DAAS

(THREE DAY SERVICE)

DENTAL CLEANING

DATE: 5/16/22

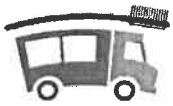
TIME: 9am

RAFFLE:

X BOX

FOOT LOCKER GIFT CARDS (2)

313-682-5888 PORTABLESMILESMOBILE.ORG "NO COST TO YOU"



PORTABLE SMILES MOBILE / SMILES OF TOMORROW

PORTABLE SMILES MOBILE & SMILES OF TOMORRROW IS COMING TO YOUR SCHOOL : DAAS

DENTAL CONSENT AND HEALTH HISTORY FORM **DATE: 05/16/22 9 THREE DAY SERVICE TIME: 9am**

Our Mobile Dentistry program includes full exam if needed, cleaning, fluoride and sealants if needed. All further treatment will receive an official referral. (**Print Clear**)

PATIENT'S/CHILD'S FULL NAME: _____

GRADE: _____ Teacher: _____

Age: _____

DOB: _____

SEX: _____

ADDRESS: _____

CITY: _____

ZIP: _____

Phone Number: _____

Medicaid (or any other insurance): _____

MEDICAL HISTORY: **HAVE YOU HAD OR BEEN AROUND ANYONE WITH COVID-19 YES OR NO (circle)**

Please Circle if patient has had any of the following: COVID-19: **Fever or Chills, Cough, Shortness of Breath, or Difficulty Breathing**

Rheumatic Fever	**Heart Disease**	**Asthma**	**Epilepsy**	**Diabetes**
Hepatitis	**Heart Murmur**	**Latex Allergies**		

Other (or please list any conditions/allergies): _____

I am the patient or the responsible party for the listed patient. I hereby authorize Portable Smiles Mobile to provide the dental treatment described. I authorize Portable Smiles Mobile and Smiles Of Tomorrow to access my dental records and findings. I authorize Portable Smiles Mobile to bill on my behalf, and to use Medicaid (or other insurance)/Delta Dental insurance information for billing purposes. By signing this document, the patient, parent, authorized representative and/or guardian further acknowledges that they understand that treatment obtaining duplicate services at a mobile dental facility may affect benefits that he or she receives from private insurance, a state or federal program, or other third-party provider of dental benefits.

* Patient will be seen again in 6-months for follow-up service *

PARENT/PATIENT'S SIGNATURE: _____ **DATE:** _____

BY SIGNING THIS FORM, I UNDERSTAND THAT:
HIPPA COMPLIANCE: PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED FOR TREATMENT, INSURANCE, OR HEALTHCARE OPERATIONS.