

The Smiles Movement



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Please return this form to the school!

DEAR CONCERNED PARENT:

Dental disease is the #1 reason children miss school. The Smiles Movement has been providing care for your children for over 30 years at no charge to you. You have a choice; you can choose to go through the process at IHS, or enjoy the convenience of having our experienced doctors care for your child at their school. We thank you for once again choosing our practice that over the years has served thousands of children. To participate, your child must be enrolled in an appropriate AHCCCS program which is easily done at most IHS facilities.

IF YOU CHOOSE TO HAVE YOUR CHILD CONSIDERED FOR TREATMENT YOU MUST COMPLETE THE FOLLOWING:

Child's Name _____ Male _____ Female _____

Child's Social Security Number _____ Date of Birth ____/____/____

Emergency Contact _____ Phone # _____

School Name _____ Teacher's Name _____ Grade _____

HEALTH HISTORY

PLEASE TELL US ABOUT YOUR CHILD'S HEALTH HISTORY. CHECK ALL OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

Has your child had?	NO	YES		NO	YES
Allergy to medication	___	___	Heart Murmur	___	___
Rheumatic Fever	___	___	Bleeding Disorders	___	___
Psychiatric Treatment	___	___	High Blood Pressure	___	___
Seizure Disorder	___	___	Asthma	___	___
Diabetes	___	___	Hepatitis/Jaundice	___	___
AIDS/HIV Positive	___	___	Anemia	___	___
Hospitalizations	___	___	Latex Allergy	___	___
Vision or speech problems	___	___	Other Serious Illness	___	___
Could your child be pregnant?	___	___			

Is your child under a Physician's care? NO ___ YES ___

Is your child taking any medication? ___

Any problems with local anesthetic? ___

PLEASE EXPLAIN ANY "YES" ANSWERS: _____

What is your primary concern for your child's oral health? _____

PLEASE TURN OVER AND COMPLETE

CONSENT FOR TREATMENT AND PATIENT MANAGEMENT

Following your child's examination, that consists of radiographs (x-rays) and in some cases, a panoramic scan, and cleaning, the doctor may determine that your child requires additional dental treatment, including silver fillings, routine baby tooth extractions, stainless steel crowns, and pulp treatments for deciduous (baby) teeth. These pulp treatments are routine procedures for baby teeth. More involved pulp treatments for permanent teeth (root canals) are referred.

The Smiles Movement dentists make all decisions very carefully, including referring your children who may benefit from sedation, protecting your child from injury with a gentle hand, or in the event of a critical situation, briefly using a papoose board similar to those used by physicians and hospitals. It is always our priority to give your child excellent dental care, protect them, and create a pleasant visit. These efforts will help insure positive dental experiences for a lifetime of smiles. If our dentists make the decision to refer your child, they take all factors into consideration, including the very limited number of general anesthesia appointments available at the IHS. We coordinate our schedules with the school nurse, and we welcome and encourage you to participate, however, we do understand that in some circumstances you cannot attend.

We have had great success with our program and we are looking forward to providing your child with excellent dental care. Participation in this program could affect future benefits your child may receive under private insurance or from another private dentist.

- HELP US COMBAT DENTAL DISEASE, THE #1 CAUSE OF MISSED SCHOOL TIME
- WE WANT TO GIVE YOUR CHILD A SMILE THAT LASTS A LIFETIME

CONSENT FOR TREATMENT

AND

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I acknowledge that: (Please check one below)

1. _____ YES. I give permission for my child to receive necessary treatment!

I am aware that I have rights outlined in the Notice of Privacy Practices and that a copy of this notice is available for my review.

I consent to the sharing of this information with the IHS Dental program.

2. _____ No. I do not want my child to receive necessary dental treatment provided at their school. I will assume responsibility for obtaining their treatment elsewhere.

I understand that I may refuse to sign this Consent and Acknowledgement.

X _____ Date _____
Parent or Guardian

Please print your name _____

If you have any questions, please call our office at 928-567-1832

PLEASE TURN OVER AND COMPLETE
