



Miles of Smiles, Inc.

Must complete both sides of form

Patient's name _____ Today's date _____
 Patient's address _____ City _____ State _____ Zip _____
 Home phone _____ School _____ Teacher _____ Lunchtime _____
 Patient's date of birth _____ Age _____ Social Security # _____ Sex M F (circle one)
 Child Medicaid # _____ Plan Information _____
 Race (circle one) Caucasian American Indian African American Asian Hispanic Other _____
 Emergency contact _____ Contact phone # _____
 Physician name _____ Physician phone # _____

Parent/guardian name _____ Relationship to patient _____
 Parent/guardian date of birth _____ Social Security # _____ E-mail _____
 Parent/guardian address _____ City _____ State _____ Zip _____
 Home phone _____ Work phone _____ Place of employment _____

Health/Dental history

PLEASE CHECK any of the following that your child had or presently has:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart/Vascular Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer/Leukemia |
| <input type="checkbox"/> Heart murmur → <input type="checkbox"/> pre-med required? | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy/Seizures | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Mental Disability | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Other _____ |

CHECK any of the following that your child is **ALLERGIC** to or has had an adverse reaction to:

- | | | | |
|---------------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex (balloons, gloves, rubber, etc.) |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other _____ | | |

Is your child taking medications? Yes No

If yes, list medications and reason for taking _____

Has your child ever seen a dentist before? Yes No

If yes, who? _____ When? _____

Does your child have any dental pain now? Yes No

If yes, how long? Days Weeks Months

I give my informed consent for the dentists and their auxiliary staff to take x-rays of my child's mouth and provide the care the dentist deems necessary for the treatment of his/her oral condition. I will receive information advising me of my child's oral health needs.

I also authorize the release of information for any applicable insurance coverage.

Please check any procedure you would NOT like completed in our program:

- | | | | | |
|---|--------------------------------------|--|--|-----------------------------------|
| <input type="checkbox"/> Exam | <input type="checkbox"/> Sealants | <input type="checkbox"/> Extractions | <input type="checkbox"/> X-rays | <input type="checkbox"/> Fillings |
| <input type="checkbox"/> Pulpotomies | <input type="checkbox"/> Cleaning | <input type="checkbox"/> Chrome crowns | <input type="checkbox"/> Space maintainers | |
| <input type="checkbox"/> Fluoride application | <input type="checkbox"/> Other _____ | | | |

1

_____	_____	_____	_____
Patient's signature or Parent or Guardian	Date	Dentist signature	Date

*We will be unable to see your child unless both sides of the form are completed and **all three signature lines are signed (1 signature on front) Please complete back of form (2 additional signatures on back of form)***

Turn over →

Portable Dental Program 2011

Income Guidelines to receive services — 200% of Federal Poverty Level guidelines

You must provide your household income to be eligible for free dental care from Miles of Smiles, Inc.

List names of all household members	Gross monthly earnings (before deductions)	Monthly welfare, child support, alimony	Monthly payments from pensions, retirement, Social Security	Any other monthly income
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$

2

Signature of Adult Household member _____

I certify that all of the above information is true and correct and current. I understand that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal Laws.

HIPPA Notice: (Attached sheet)

We are required by law to give you a copy of the HIPPA notice and to obtain your written acknowledgement that you have received a copy of this notice.

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

3

Signature of Parent/Legal Guardian/Patient's Representative

1

&

2

&

3

Signature required

***** We will be unable to see your child unless both sides of the form are completed and all 3 signature lines are signed. *****