Smile Squad
1111 Ninth Street Suite 190, Des Moines
Phone 515.244.9136 x 124 Fax 515.244.9153

Nolden Gentry Dental Clinic
1800 Grand Ave, Des Moines IA
Phone 515.242.8488 Fax 515.242.8489

Dental Connections, Inc. provides dental services at several school locations!

If your child already has a dentist, we encourage you to make an appointment with that dental office.

STUDENT'S NAME: _____

PLEASE MARK YES OR NO FOR LOCATION PERMISSIONS.

YES! My child can have dental services at school.

PLEASE CHECK MARK which locations you're authorizing service for.

OPTION A: ☐ **Dental services at Nolden Gentry DMPS dental clinic.**

OPTION B: ☐ **Dental services at Nolden Gentry clinic WITH transportation provided by Dental Connections.**

PLEASE READ AND SIGN (If you selected YES above)

By signing this form I authorize Dental Connections to provide any dental treatment listed in the "services" section to my child as deemed necessary by the dentist or hygienist. I certify that the information provided by me is accurate to the best of my knowledge. I authorize payment of insurance benefits directly to the Dental Connections. For services provided on the mobile units, I understand some services may be provided by a dental hygienist because of limited access to dental services in the community and do not take place of regular dental care in a dental office. I authorize the sharing of information regarding my child between the Dental Connections and Des Moines Public Schools. I understand my child may be photographed while participating with this program and the purpose of such photographs is for clinical documentation and/or promotion of the Smile Squad Program.

NOTICE OF PRIVACY PRACTICES:

I understand the Notice of Privacy Practices of Dental Connections, Inc. is available upon request and is also accessible on the Dental Connections website. I have had full opportunity to read the Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to the Dental Connections to use and disclose mine or my child's protected health information to carry out treatment, payment activities, and healthcare operations. I understand that I have the right to revoke this consent at any time by giving written notice and that my revocation could result in the discontinuance of treatment by Dental Connections. I further understand that Dental Connections reserves the right to change the Notice of Privacy Practices as they have been described. If the Notice of Privacy Practices is revised, I will be issued the new Notice of Privacy Practices that contains the changes. Those changes may apply to any of my protected health information.

SIGN HERE **Signature of parent:** _____ **Date:** _____

TRANSPORTATION CONSENT:

Transportation Consent is active for the length of this permission form (1 year). In signing, I understand this authorizes Dental Connections' to transport my child from their school location to the Des Moines Public Schools' Central Campus location for their dental care. I understand that my child will be traveling in a motor vehicle driven by an adult and they are required to wear their seatbelt while traveling. My child is expected to respect the driver, the vehicle, and the other students being transported and remain seated during the course of the trip. I understand riding in a vehicle may result in personal injuries or death from wrecks, collisions, or acts by riders, other drivers or objects. I understand my child is not required to participate in this, but I grant permission to do so in order for them to receive dental treatment. I verify that I have been informed of potential risks, that I have full knowledge of the risks involved in transportation, and I assume any expenses that may be incurred in the event of an accident, illness, or other incapacity, regardless of whether I have pre-authorized such expenses. As a condition of the transportation received, I, for myself, my child, my executors and assigns, further agree to release and forever discharge Dental Connections, Inc. and their agents, officer, employees, and volunteers from any claim that I might have myself or that I could bring on my child's behalf with regards to any damages, demands or actions whatsoever, including those based on negligence, in any manner arising out of this transportation.

SIGN HERE **Signature of parent:** _____ **Date:** _____

IF SIGNING FOR PERMISSION, PLEASE COMPLETE THE BACK OF THIS FORM.

STUDENT'S NAME: _____ **SCHOOL:** _____ **TEACHER**_____ **GRADE**____

CHILD'S BIRTHDAY:_____ ☐**Male** ☐**Female**

Child's Social Security # ___

Parent name (if student under 18) _____

Phone number _____

Address_____

City/Zip_____

Email_____

When was your child's last dental exam?
□Never □3-6 months ago □6-12 months ago □ 12+months ago

Which do you consider your child? □White □Hispanic-Latino □African-American □American-Indian □Other

Does your child qualify for free/reduced lunch at school? □Yes □No

SERVICES

Examination & X-rays - An exam determines the dental needs of your child. X-rays check for cavities, infection, and tooth eruption.

Sealants - A protective coating is applied to the chewing surface of molars to help prevent cavities.

Fluoride - A protective coating is applied to all teeth to strengthen tooth enamel.

Fillings - Fillings "fix" a cavity. Decay is removed and replaced with silver or white filling material, using anesthetic if necessary. If left untreated a cavity can cause an infection.

Extraction (baby teeth) - Extractions are necessary if the cavity is too large to fix, the tooth is infected, or if the tooth won't came out on its own, using anesthetic if necessary.

Silver crowns (baby teeth) - Silver crowns are placed on teeth with large cavities and remain until the tooth comes out, using anesthetic if necessary.

Teeth cleaning - A dental cleaning removes plaque and tartar and helps to prevent cavities and gingivitis.

Name of child's dentist_____ Name of child's medical doctor_____

1. Has your child been treated for any of the following? Please mark any YES answers

☐ **NONE** ☐ Asthma ☐ Kidney problems ☐ High blood pressure ☐ Diabetes
☐ Seizures ☐ Epilepsy ☐ Infectious Hepatitis ☐ Liver problems ☐ HIV/AID
☐ ADD/ADHD ☐ Behavioral concerns ☐ Heart defect ☐ Tuberculosis (TB) ☐ Anemia
☐ Heart murmur

2. Has your child ever had a serious illness not listed above? ☐ No ☐ Yes (explain) _____

3. Does your child need medicine before dental treatment because of heart or other medical conditions? ☐ No ☐ Yes
(why?)_____

4. Is your child allergic to any of the following? Please mark any YES answers

☐ **NONE** ☐ Anesthetics ☐ Sulfa ☐ Latex ☐ Penicillin/Amoxicillin ☐ other (list)_____

5. Is your child under the care of a doctor now? ☐ No ☐ Yes (why? _____

6. Has your child ever been hospitalized overnight? ☐ No ☐ Yes (when? why?) _____

7. Does your child take any daily medications? ☐ No ☐ Yes (list) _____

8. Has your child ever had a head or mouth injury? ☐ No ☐ Yes (explain) _____

9. Do you think your child has any cavities/toothaches? ☐ No ☐ Yes

INSURANCE INFORMATION (Please select 1)

☐ **Student has Medicaid #**_____

☐ **Student has Hawk-I #**_____

☐ **Student does not have dental insurance**

If your child has Medicaid, Hawk-I or dental insurance a claim will be submitted for services provided.

☐ **Student has dental Insurance through a parent:** Name of parent _____

Parent birthdate_____ Social Security # or Insurance ID #_____

Employer name_____ Dental Insurance Company name_____