FOR:
Children 0-20 years old with Medicaid insurance/Healthy Kids Dental or uninsured who:
- Live or attend school in Ottawa County
- Do not have a dentist
- Have not had a dental checkup in the last 6 months
- Are on free/reduced lunch

WHAT WE DO:
- Dental checkup
- Teeth cleaning
- Fluoride treatment to prevent cavities
- X-rays
- Sealants
- Dental health education
- Fillings and extractions if needed
- Other necessary dental treatment

HOW TO SIGN UP:
1. Complete the attached form, sign it and return to your child’s school immediately.
2. Child’s Medicaid Recipient /Healthy Kids ID # must be written on attached form (if eligible)
3. Financial information must be completed on attached form.
4. Parent must complete the attached health history form every year.

Although your child may be moving into middle school or high school, Miles of Smiles can still provide dental services through the age of 20. You will need to call us at 1-800-467-5905 to schedule an appointment at a location near you.

Información en español en el otro lado de esta página.
If your child has a dentist, please DO NOT complete this form

Please complete and return to your child’s school IMMEDIATELY

Child’s Name: ___________________________________________ Male / Female ______ Date of Birth ____/____/____

Parent’s Name: ___________________________________________ Phone: (_____) _____-________

Address: __________________________________________________ Alt. Phone: (_____) _____-________

Ethnic/Racial Background: African American Arab/Chaldean Asian/Pacific Islander Hispanic Native American White/Caucasian

Children’s Medicaid/Healthy Kids Dental ID#: __________________________ Child’s Social Security # __________________________

Child of Migrant Farm Worker: Yes / No School Name: __________________________ Grade:______ Teacher: ____________

Has child been seen on Miles of Smiles before? Yes / No If yes, name of school:

To receive dental services this portion must be completed: Have you applied for Medicaid coverage for your child in the last 90 days? Yes/No

If duplicate services are obtained elsewhere; it may affect your child’s ability to receive benefits.

Has child been hospitalized? Yes / No

Does your child have any allergies to drugs, foods or latex?

Please list why and when:

Is your child under the care of a doctor for any medical condition?

If yes, what medical condition?

Is your child taking any medications?

If yes, medication and reason for taking them:

Has your child been hospitalized?

Please list why and when:

Does your child have any allergies to drugs, foods or latex?

Please list:

Does your child have any cognitive/ emotional impairments?

If yes, please explain:

Please provide any additional details on your child’s health:

I hereby grant Ottawa County Department of Public Health (OCDPH) permission to perform all dental services on my child, including the use of Nitrous Oxide, x-rays, prophylaxis (cleaning) sealants, fluoride, fillings, pulpotomy (baby tooth nerve treatment), stainless steel crown or extractions. I also grant permission for dental, hygiene and dental assisting students, under the direct supervision of a licensed dental professional, to provide dental services for my child. I understand that if an HIV or hepatitis test may be performed on him or her without consent in the event that an OCPH employee or a dental provider sustains a needle stick injury. Mucous membrane or open wound exposure to my child’s blood or other body fluids. In the event of an emergency, I authorize an adult to seek medical attention for my child. I give permission for a school employee to transport my child to OCPH’s designated medical facility.

This consent is good for one year from date of signature. I certify that the above information is true and correct to the best of my knowledge. I hereby authorize OCPH to verify the information above. Please inform us of any Medical history changes by calling 800-467-5905.

I understand that if I have given false information this may disqualify my child from receiving dental services. I certify that I give full consent to have my child photographed, videotaped and/or interviewed on Miles of Smiles dental mobile unit. I also give full consent for said photographs, videotapes and/or interviews to be published for health agencies use and/or news media releases. Dental records may be made available to schools, Head Start programs, dental offices, clinics, health agencies, assistance programs and your health insurance plan, upon request. I have been informed that the HIPAA Privacy Notice is available on the county website www.miOttawa.org/dental. A copy of the HIPAA Privacy Notice is also available upon request by calling 616.494.5540

Signature of parent or legal guardian __________________________ Relationship __________________________ Date ________________

Children and Families Division

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