Print clearly in ink and completely fill out the form. Signature is required for your child to be treated.

Child's Information

School or Organization _____

County_____ Grade _____

Teacher/Care Manager _____ Room #_____

Child's Legal Name _____

Date of Birth____/____/____ **Gender** Male Female Other

Race White Black/African American Asian Other

Parent/Guardian/Responsible Party Information

Name _____

Contact Number ( ) _____

Street Address _____

City_____ State _____ County_____ Zip_____

Relationship to Child _____

Email _____

Is this your very first visit to a dentist? YES / NO

When was your child's last dental checkup?_____

Health & Medical Information

Please list any medications your child is currently taking: _____

_____

Please check the box that applies to the patient. Has the child had any history of, or conditions related to, any of the following:

- ❑ ADHD
- ❑ AIDS/HIV Positive
- ❑ Allergies: _____
- ❑ Asthma
- ❑ Blood Disorders
- ❑ Diabetes
- ❑ Heart Murmur (requiring pre-medication)
- ❑ Heart Murmur (not requiring pre-medication)
- ❑ Heart Valve Replacement
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ Kidney Problem
- ❑ Latex Allergy
- ❑ Seizures
- ❑ Shunts or Artificial Joints
- ❑ Tuberculosis
- ❑ Other: _____

Medicaid

❑ My child is covered by Virginia Medicaid/FAMIS. 12 digit Medicaid ID number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Dental Insurance

My child is covered by a commercial dental insurance and I would like to have their Smile Time™ visit submitted to their insurance.

Insurance Carrier Insurance _____

Company Phone ( )_____

Subscriber_____ Relationship to Patient_____

Birth Date of Subscriber____/____/____

Phone Number of Subscriber( ) _____

Employer Name/Group _____ Insurance ID #_____

Uninsured Low Income Families

My child does not have Medicaid or dental insurance; however does receive free or reduced lunch or our family income is at 200% or below federal poverty guidelines. (Please circle which category applies to your annual household income)

Family Size	Annual Household Income
2	$31,920
3	$41,560
4	$50,200
5	$58,840
6	$67,480

❑ I have attached a $75 money order for the Smile Time™ visit.

❑ I would like to pay $75 by Visa/Mastercard. Please call me at ( ) _____

No Medicaid, No Dental Insurance, or Financially Overqualified for discounted visit

My child does not have Medicaid, Dental Insurance, and our family's household is 200% or above Federal Poverty Guidelines.

❑ I have attached a $125 money order for the Smile Time™ visit.

❑ I would like to pay $125 by Visa/Mastercard. Please call me at ( ) _____

Consent for Services and Care

As a custodial parent or legal guardian of the child listed above, I authorize PRDC to treat the above named patient and disclose, when requested, any and all information for any illness or injury, medical history consultation, prescriptions or treatment and copies of all medical records. I assign or authorize direct payment to PRDC toward any medical procedures performed and authorize PRDC to file claims on my behalf. I understand that I am responsible for services not covered by my insurance plan or if my insurance is not in effect at the time of service. I understand that PRDC renders services without regard to race, creed, color or national origin. I allow for school nurse/school representatives, my child's physician, and/or the dentist of my choice to obtain dental records and radiographs. I understand my child will receive a dental treatment plan and a contact follow up call will be made within 72 hours of the dental visit. I understand by signing this consent is valid for the entire school year.

Signature of Patient, Parent or Guardian

_____

Date_____

Piedmont Regional Dental Clinic

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