School of Dental Medicine

S-Miles To Go Mobile Dental Program

PATIENT INFORMATION		DATE:	
Child's Name:		Sex: M / F	**Birth Date:** / /
Address:	City:		Zip Code:
Phone:	**Child's Social Security Number:**		
Child's School:	Teacher's Name:		
PARENT OR GUARDIAN INFORMATION			
Parent/Guardian Name:		Sex: M / F	**Birth Date:** / /
Address:	City:		Zip Code:
Social Security Number:	Home Phone:		
Work Phone:	Cell Phone:		

PLEASE ANSWER QUESTIONS BELOW BY CHECKING THE BOX

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Students Primary **Language is:**	Does the student need an interpreter? ☐ Yes ☐ No

HEALTH INFORMATION		
IS YOUR CHILD IN GOOD HEALTH?	☐ Yes	☐ No
If no, explain:		
NAME OF CHILD'S **Medical** Doctor:		
IS YOUR CHILD TAKING ANY MEDICATIONS?	☐ Yes	☐ No
If yes, list medications:		

IS THIS YOUR CHILD'S FIRST DENTAL VISIT?	☐ Yes	☐ No	☐ Not sure
If no, has it been over **6 months** since his/her last visit?		☐ Yes	☐ No
DOES YOUR CHILD HAVE ANY EXISTING DENTAL PROBLEMS/CONCERNS (toothache, loose tooth, swelling?)		☐ Yes	☐ No
If yes, explain:			

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?

Heart Disease	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Blood Transfusions	☐ Yes	☐ No
Sickle Cell	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No	Prolonged Bleeding	☐ Yes	☐ No
Hepatitis / Liver	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Emotional disorder(s)	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Allergies **	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Other?	☐ Yes	☐ No	Speech or Hearing Impaired	☐ Yes	☐ No

**** Please list known allergies:**

UB Dental Provider's Signature: **OVER →**

CHILD'S PREVIOUS DENTIST IF ANY:

PLEASE CHECK ONE BOX ONLY

☐ Yes, I would like my child **to have a dental examination including x-rays (if needed), cleaning, fluoride treatment, sealants** (a coating that protects teeth from cavities), **fillings and other treatment as needed** by a licensed dental provider and/or dental student who is supervised by a licensed dental provider.

☐ Yes, I would like my child **to have a dental screening and oral health education (no charge to you)** by a licensed dental provider and/or dental student who is supervised by a licensed dental provider.

**** A report form will be sent home with your child****

DENTAL CONSENT FORM: (IN ORDER FOR US TO TREAT YOUR CHILD, YOU MUST SIGN ON THE NEXT PAGE INDICATING YOU HAVE READ AND AGREE TO THE FOLLOWING INFORMATION)

Financial Responsibility/Assignment of Benefits:

I authorize The UB School of Dental Medicine (UBSDM) to apply for benefits on my behalf to my child's insurance carrier and request my child's insurance company pay directly to UBSDM insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify UBSDM of any changes. **If your child has had a dental cleaning within the past 6 months and you have used your insurance, he/she is not eligible for insurance reimbursement at this time. Medicaid, Child Health Plus, and Private Insurance accepted as payment in full.**

Responsible Party: (This is the individual who is responsible for the payment of your child's bills)

Name: _____Date of Birth _____Social Security#_____

Mailing Address: _____City: _____State: _____

Zip Code: _____Phone Number: _____ Relationship to Child _____

○ **No,** my child **DOES NOT** have **dental** insurance (you will be contacted by program staff)

○ **Yes,** my child **HAS dental** Insurance (This information can be found on the dental insurance card that covers your child.)

Dental Insurance Name: _____ **ID Number:** _____
(Example: Medicaid, Fidelis, Your Care, Independent Health etc.) (Number is on the card)

CIN Number (Example: AB12345CD): _____**Sequence Number:** (Example: 02, 43, 69) _____

Please complete this section if your child has dental insurance through your Employer:

Private **Dental** Insurance Name (Example MetLife, Delta Dental, Guardian): _____

Subscriber/Enrollee ID: _____Group Number_____ Date of Birth_____

Group Name: _____ Employer: _____
Insurance Company Street Address:

_____City_____State_____Zip_____

Name of person who carries the insurance: _____Relationship to patient_____