Smiles For a Lifetime
A WELVISTA PROGRAM

Parent Consent Form - Clarendon

Please fill out, sign, and return to your child's school nurse or Smiles office IMMEDIATELY.

Child's Name: _____ **Male**_____ **Female**_____
(First) (Middle) (Last)

Date of Birth: _____ **Social Security Number**: _____

Race: African American _____ Caucasian_____ Hispanic_____ Asian_____ Indian_____ Other_____

Permission to Photograph: ☐ Yes ☐ No (photos will be used for SMILES social media and marketing)

School: _____ **Grade**: _____ **Homeroom Teacher**: _____

Child's Mailing Address: _____ **City**_____ **State**_____ **Zip**_____

Parent/Guardian 1's Name: _____ **Parent/Guardian 2's Name**: _____

Home Phone #: _____ **Emergency Phone #**: _____

Parent 1's Cell #: _____ **Parent 1's: Work #**: _____

Parent 2's Cell #: _____ **Parent 2's: Work #**: _____

I freely give my permission for my child to receive services from Smiles for a Lifetime during the school year. Treatment will include all standard dental procedures and may involve "numbing the mouth" with a local anesthesia and/or use of nitrous oxide. I understand that my child will be seen at Smiles for a professional dental exam, dental cleaning, and/or treatment. Treatment is provided by a S.C. licensed dentist and dental professionals.

I further release from liability the staff of Smiles for a Lifetime and the School District. I understand that treatment is given to us voluntarily and I have freely accepted.

I authorize release of any information to process my dental claims to Medicaid or my private insurance company. I authorize and direct payment to Smiles for a Lifetime. I request and authorize the release of any information concerning the above child for proper treatment and care. I understand the Smiles for a Lifetime Notice of Privacy is posted at the dental center and a summary is printed on the reverse side of this form.

Parental Signature: _____ **Date**: _____

<u>If Child Has Medicaid</u>: **List their Medicaid Number**: _____

<u>If Child Has Private Insurance</u>:
(I hereby authorize payment directly to Smiles for a Lifetime of the group insurance benefits otherwise payable to me)

Signature of Policy Holder: _____ **Date**: _____

Employee Name: _____ **Date of Birth**: _____ **Social Security/ID #**: _____

Employer: _____ **Name of Insurance Company**: _____

Address to Mail Claim: _____ **Insurance Co. Phone #**: _____

Group #: _____ **Policy #**: _____

Please Complete The Back Side Of This Form >>>

Child's Name: _____

Health History – ALL QUESTIONS MUST BE ANSWERED

Please Check All That Apply

Autism ☐	Seizures ☐	ADD/ADHD ☐	HIV/AIDS ☐
Heart Murmur ☐	Kidney Problems ☐	Hepatitis A, B, C ☐	Liver Problems ☐
High Blood Pressure ☐	Digestive Problems ☐	Anemia/Blood Disease ☐	Latex Allergy ☐
Sickle Cell ☐	Cancer/Chemo ☐	Asthma ☐	Diabetes ☐

1. **Certain medical conditions such as: Orthopedic plates/pins; Heart surgery/vessel/valve replacement may require antibiotic pre-medication**.

   Please list your child's condition: _____

2. **Does your child have any allergies?** (food, medication, etc.) ☐ Yes ☐ No

   Please list what they are allergic to: _____
   _____

3. **Is your child taking any medications?** ☐ Yes ☐ No

   Please list medications: _____

4. **Who is the name of your child's medical doctor**: _____

5. **What is the name of your pharmacy**: _____

Attestation of Privacy Policy

I attest that the information on this form is complete and accurate. By my signature on this permission form, I authorize the release of information about my child's medical condition(s) to Welvista/Smiles for a Lifetime. I authorize Welvista Smiles to use and disclose such information for enrollment into the Smiles program, which may include contacting and providing information to social workers, state agencies, healthcare providers, or other person or entities Welvista Smiles may deem appropriate to release medical records or required information bearing on my eligibility and benefits under the program. Additionally, I agree that at any time during my enrollment Welvista Smiles may request additional documentation to authenticate the statements made on my application. I will notify Welvista Smiles if I become eligible for Medicaid, health insurance, or if there is a change in my mailing address. I also acknowledge I have received Welvista Smiles Notice of Privacy Practices Statement.

SCAN HERE

For more information about our Notice of Privacy Practices scan this QR code or visit **https://bit.ly/WelvistaPrivacy**

Smiles for a Lifetime – Clarendon
16 Weinberg St.
Manning, SC 29102
803-435-9555
Welvista.org/smiles