PARENT OR GUARDIAN PERMISSION FORM

ALLENDALE SMILES FOR A LIFETIME

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

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

Check one: African American _____ Caucasian _____Hispanic_____ Asian_____ Indian_____ Other _____

Date of Birth: _____ Social Security #: _____

School: _____ Grade: _____ Homeroom Teacher: _____

Child's Mailing Address: _____
(Mail delivery address) (City, State, Zip)

Parent or Guardian's Name: _____

Home Phone# _____ Mother's Cell# _____ Father's Cell# _____

Emergency# _____ Mother's Work# _____Father's work# _____

I freely give my permission for my child to receive services from Allendale 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 transported, by the Allendale School System, for a professional dental exam and/or treatment. Treatment is provided by a S.C. licensed dentist and dental professionals.

I further release from liability the staff of Allendale Smiles for a Lifetime and the Allendale School System. 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 Allendale 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 Allendale Smiles Notice of Privacy is posted at the dental center and a summary is printed on the reverse side of this form.

_____ _____
(DATE) (PARENTAL SIGNATURE)

IF CHILD HAS MEDICAID:

My child has Medicaid (list the Medicaid number) #_____

IF CHILD HAS PRIVATE INSURANCE:

I hereby authorize payment directly to Allendale 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. Telephone# _____

Group # _____ Policy #_____

PLEASE COMPLETE HEALTH HISTORY ON REVERSE SIDE OF FORM

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Child's Name: _____

HEALTH HISTORY - ALL QUESTIONS MUST BE ANSWERED

PLEASE CIRCLE 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, latex, etc.) YES or NO (please circle)

If yes, please list what they are allergic to: _____

_____

3. Is your child taking any medications? YES or NO (please circle)

Please list medications: _____

_____

4. Who is your child's family (medical) Doctor? Name of Doctor: _____

5. What pharmacy do you use? _____

We provide preventive and restorative services to children in K-3 – 12th grades. If you have other children in your family who have not received a form, please contact our office and we will be happy to mail you a form.

SUMMARY OF PRIVACY PRACTICES

In accordance with the Privacy Regulation and Accountability ACT of 1996 (HIPPA) Notice of Privacy Practices and Patient Bill of Rights, we are required to maintain the confidentiality of your health information. We will use and disclose your protected health information to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. I authorize Smiles for a Lifetime to release information regarding treatment to third party payers or others for receiving payment for services. I further authorize Smiles for a Lifetime to exchange health care information for the purpose of continuity and coordination of care. For a full copy of the HIPPA, Notice of Privacy Practices and Patient Bill of Rights, please review at each location during operating hours.

Smiles for a Lifetime - Allendale County Schools

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