HEALTH DELIVERY INC.

Mobile Dental Program

Date of student's last Dental Visit:
_____ / _____ / _____ (Month) (Day) (Year)

PARENT/GUARDIAN CONSENT FORM: *(Please print clearly and complete the ENTIRE form, front & back)*

Student Name	**Date of Birth**	**Age**	**Male ❐ Female ❐**	**Grade**	**School**

Race /Ethnicity (Optional) – Please check ALL that apply.
❐ African American ❐ Caucasian ❐ Hispanic ❐ Asian ❐ American Indian ❐ Middle Eastern
❐ Multiracial (Please Specify)______________________________ ❐ Other (Please Specify):________________________________

Child's Address	**City**	**Zip Code**	**Home Telephone #**

Parent/Guardian: Last Name	**First Name**	**M.I.**	**Date of Birth:**	**Relationship:**

Daytime Telephone #	**Work Telephone #**	**Cell Phone #**

Name Of Emergency Contact	**Relationship**	**Telephone #**

Name of Student's Dentist	**Telephone #**

Insurance
❐ Medicaid ❐ Blue Cross/Blue Shield ❐ Delta Dental ❐ MIChild/Healthy Kids ❐ Other:____________________

I.D. #	**Social Security #**	**Subscriber's Name**	**Subscriber's Date of Birth**

Relationship To Student	**Subscriber's Employer**	**Employer's Address**

STUDENT MEDICAL HISTORY: Please check Yes or No.

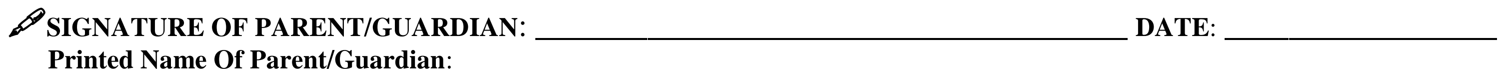
Allergies (other) type:	❐Yes ❐No	Diabetes	❐Yes ❐No
Allergies (medications)	❐Yes ❐No	Seizures	❐Yes ❐No
Asthma	❐Yes ❐No	Heart Problems type:	❐Yes ❐No
Pre-medicated for dental procedures	❐Yes ❐No	Other Medical Conditions/Medications:	

Health Delivery's Mobile Dental Program offers dental services to school-age students. I give my consent for the above named student to receive all services, listed on the front of this consent form, provided by the School-Based Dental Bus Program By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above. I understand that I may withdraw my consent for services upon written notice to Health Delivery's Dental Department at any time. I authorize Health Delivery's Mobile Dental Program to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both Health Delivery and my child's dentist to exchange health care information for the purpose of continuity and coordination of care.

Please Initial ONE Below:
I understand that by selecting YES and signing this form, I am consenting to have my child receive a dental exam, cleaning, fluoride, clinical photos and sealants (at the dentist's discretion). By selecting NO and signing this form, my child will not be treated. Make sure to read and complete both sides of this form before signing.

_____ **I Give Permission** to have my child receive dental treatment from Health Delivery School-Based Program.

_____ **I Would Not** like my child to receive dental treatment from Health Delivery School-Based Program.



SIGNATURE OF PARENT/GUARDIAN: ____ **DATE**: ____________________
Printed Name Of Parent/Guardian: ____

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CHART #: _____________ Exam: _____________ Prophy: _______________ Sealants: Y / N :_______________

LV: SB / W / BS / BP / NS INS: HK / CAID / DELTA / OTHER