DETROIT MERCY DENTAL CENTER

TITANS for TEETH MOBILE CLINIC

School Based Dental Services Program

Dental Consent and Medical History

1. **Dental exam**
2. **X-rays**
3. **Teeth cleaning**
4. **Fluoride treatment**
5. **Sealants** (*on adult molars*)
6. **Fillings**
7. **Extractions** (*baby teeth*)
8. **Pulpotomy** (*removing tooth nerve*)
9. **Stainless steel crowns** (*caps*)
10. **Dental referrals** (*as needed*)

Dear parent or guardian: The University of Detroit Mercy School of Dentistry's Titan's for Teeth Mobile Clinic (TFTMC) is pleased to provide dental care at your child's school during school hours. Dental treatment will be provided only as needed.

The treatment will be carried out by dental students under supervision of a licensed dentist and/or dental hygienist faculty. Nitrous Oxide (happy air) and/or local anesthetic (tooth numbing medicine) may be used for some procedures. If you would like for your child to receive services please complete this form and return to the School. If your child does not have dental insurance or if you have any questions about the program, please contact our Mobile Program Coordinator at (313) 355-0390.

WOULD YOU LIKE YOUR CHILD TO RECEIVE DENTAL SERVICES IN THE TFTMC? ☐ YES ☐ NO

If you checked `YES`, please complete the information below: PLEASE PRINT CLEARLY IN INK

School Name: _____

CHILD'S INFORMATION

Child's Last Name: _____

Child's First Name: _____

M.I.: _____ Birth Date: _____ / _____ / _____ Age: _____

Male ☐ Female ☐ Grade Classroom No: _____

☐ African American
☐ American Indian/ Alaska Native
☐ Asian
☐ Caucasian
☐ Hispanic
☐ Native Hawaiian or Pacific Islander
☐ Other
☐ Unknown

Address _____

City _____ Zip Code: _____ Child's Social Security #: _____

Parent/Guardian First and Last Name:

_____

M.I.: _____ Parent's Social Security #: _____ Relationship to Student/Patient: _____

( ) _____ - _____ Home Telephone Number ( ) _____ - _____ Work Telephone Number

( ) _____ - _____ Cellular / Pager Number

Name of Emergency Contact: _____

( ) _____ - _____ Home Telephone Number

Email: _____

TURN OVER

INSURANCE INFORMATION

☐ **Child has MEDICAID:** Enter Child's 9 or 10-digit Medicaid Recipient ID Number:

☐ **Child has no dental insurance**

☐ **Child has Private Dental Insurance** *(for those with private insurance. Parent/guardian is responsible for deductibles and co-pays.)*

Insurance Plan: _____

Insurance ID Number: _____ Group Number: _____

Subscriber's Name (parent/guardian): _____

Subscriber's Birth Date: _____ / _____ / _____

Subscriber's Social Security #: _____

MEDICAL HISTORY

When was your child's last dental visit? ☐ Within the last 12 months ☐ More than 12 months ☐ Never been to a dentist

What services has your child received during last visit? _____

If your child goes to a dentist, please provide name and phone number:

_____ ( ) _____ - _____

My child's dental visits have been a good experience.	☐ Yes	☐ No
Recent dental problems	☐ Yes	☐ No
Does your child have Asthma?	☐ Yes	☐ No
Does your child have learning or emotional impairment?	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Blood disorder / anemia	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No
Vision problem	☐ Yes	☐ No
Hearing problem	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Hospitalization	☐ Yes	☐ No
Does your child have Allergies (medication, latex or food)?	☐ Yes	☐ No

What is your child allergic to? _____

Taking daily medication(s) ☐ Yes ☐ No

If yes, name of medication(s), dosage & directions (i.e., albuterol): _____

Condition for medication(s) (i.e., asthma, allergies, ADHD, eczema):

_____

Are medications at the school? ☐ Yes ☐ No

If not where are they? _____

Has your child had any serious health conditions not mentioned above? ☐ Yes ☐ No

Describe: _____

Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? ☐ Yes ☐ No

Please explain any Yes answer(s): _____

Please provide the name and number of your child's doctor:

_____ ( ) _____ - _____

1. I am the legal guardian of the child. I have read and understand the information on this form. This form is to obtain my consent for dental treatment for my child. By signing, I give permission for my child to receive dental treatment from the TFTMC.
2. I understand that these services can be obtained at the office of my child's dentist rather than at the TFTMC and may affect benefits that my child receives from private insurance, a state or federal program, or other third-party provider of dental benefits.
3. I have answered every question above completely and accurately. I will inform the TFTMC of any change in my child's health and/or medications.
4. I understand that the TFTMC will bill my child's private insurance or Medicaid if available and that I will be required to provide my insurance information to receive the services.

****If your child does not have dental insurance, please contact the coordinator at (313) 355-0390 for additional options****

Signature of Parent/Guardian

_____ Date _____ / _____ / _____

FORM MUST BE FILLED OUT COMPLETELY IN ORDER FOR YOUR TO CHILD TO RECEIVE SERVICES.