



Dental Services Consent Form

Sagebrush Smiles is a dental program designed to deliver high-quality, safe, and cost-effective dental care in a mobile setting.

Your child will be seen by a **licensed dentist** and may receive a wide variety of services including oral health screenings, oral health education, dental sealants, dental cleanings, fluoride treatments, and/or emergency services. Your child will receive information about healthy lifestyle choices, diet and nutrition, and have the opportunity to ask us questions about how to maintain a healthy mouth. **THERE IS NO FEE** for the child or family. However, we do bill Medicaid and receive funding from local, state, and national partners in the form of grants and donations. Collecting information on the services we provide is very important to continuing to serve our community. In order for your child to receive no fee dental services, this **CONSENT FORM MUST BE SIGNED**. This is confidential information and will not be shared. You will never receive a bill.

CHILD'S INFORMATION

Child's Full Legal Name: _____ Date of Birth: _____
Age: _____ School: _____ Grade: _____ Student ID (optional): _____
Teacher: _____ Eligible for Free/Reduced Lunch (circle one): Yes No
Child's Race (circle all that apply): *White/Caucasian* *African American/Black* *American Indian/Alaska Native*
Hispanic *Mixed Race* *Asian* *Other*

CHILD'S MEDICAL HISTORY

Is there anything about your child's health that we should know about? _____

Does your child have any allergies? _____

List all medications: _____

Last Dental Visit (circle one): *Less than 6 months* *6-12 month* *1-2 years* *Over 3 years* *Never*

Name of Current Dentist: _____ Does your child have dental pain? (circle one) Yes No

Does your child have dental insurance? (circle one) *No Insurance* *Medicaid* *Private Dental Insurance* *Other*

If Medicaid, Medicaid number is required: _____

PARENT & HOUSEHOLD INFORMATION

Parent/Guardian Name: _____ Phone: _____

Address: _____ Email: _____

Parent/Guardian Employed: (circle one) Yes No Annual Household Income: _____

Housing: (circle one) *Own* *Rent* *Homeless* *Other* Adults In Household: _____ Children in Household: _____

Healthcare Barriers You May Have (circle all that apply): *Cost* *Transportation* *Language* *Hours*

Finding Office that Accepts Medicaid *Special Needs* *Other (please specify):* _____

Do you authorize a licensed dentist to provide no fee dental care to your child? Consent includes:

- Permission to communicate with you about your child's dental needs via paperwork, emails, text, phone calls, etc.
- Dental services listed above and release Sagebrush Smiles of liability for adverse outcomes
- If applicable, submit for reimbursement to third party payers, such as Medicaid or help with enrollment
- Data collection, surveys, use of images, and follow up referral and case management
- Consent is provided on an annual basis (for the next 12 months)
- If you wish to decline consent on one or more services, please draw a line through the item above

Parent/Guardian Signature: _____ **Date:** _____