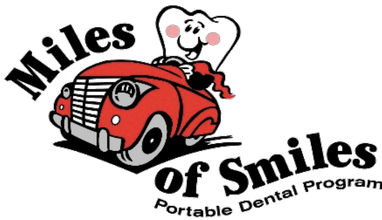

FREE DENTAL CARE

Miles of Smiles, Inc.

PORTABLE DENTAL PROGRAM
5416 NE Antioch Rd • Kansas City, MO 64119 • 816.413.9009

TODAY'S DATE: ____________________

CHILD'S INFORMATION

Child's Name: ______________________ Child's Birthday: __________ Child's Age: ______
Child's Address: ______________________ City: __________ State: ______ Zip: ______
Social Security Number: __________ Sex: MALE / FEMALE Language Spoken at Home: __________
Race (circle which apply): Caucasian American Indian African American Asian Hispanic Other: __________
School: __________________ Grade: ________ Teacher: __________________
Physician's Name: ______________________ Physician's Phone #: __________________

MEDICAID / INSURANCE INFORMATION

Child's Medicaid #: __________ Plan Information: ______________________
Private Insurance (circle)? YES or NO If YES, which plan? ______________________

PARENT / GUARDIAN INFORMATION

Parent / Guardian Name: ______________________ Relationship to Child: __________
Parent / Guardian Date of Birth: __________ Social Security #: __________
Address (if different from child): ______________________ City: ______ State: ______ Zip: ______
Home Phone #: __________ Cell Phone #: __________ Work Phone #: __________
Place of Employment/Occupation: ______________________

MEDICAL / DENTAL HISTORY

PLEASE CHECK any of the following that your child had or presently has:

❒ Heart/Vascular Disease ❒ Asthma ❒ Kidney Disease ❒ Cancer/Leukemia ❒ Diabetes
❒ Epilepsy/Seizures ❒ Anemia ❒ Rheumatic Fever ❒ Liver Disease ❒ Bleeding Tendency
❒ Mental Disability ❒ ADHD ❒ Heart Murmur → ❒ Pre-Med Required?
❒ Physical Disability ❒ Other: ______________________

CHECK any of the following that your child is **ALLERGIC** to or has had an adverse reaction to:

❒ Aspirin ❒ Local anesthetic ❒ Penicillin ❒ Latex (balloons, gloves, rubber, etc.) ❒ Erythromycin
❒ Other: ______________________

Is your child taking medications? ❒ Yes ❒ No If YES, please list medications and reason for taking: __________
____

Has your child ever seen a dentist before? ❒ Yes ❒ No If yes, who? __________ When? __________
Does your child have any dental pain now? ❒ Yes ❒ No If yes, how long? ❒ Days ❒ Weeks ❒ Months

For more information about our services and organization, please visit www.milesofsmilesinc.org or call our office at 816.413.9009

We will be unable to see your child unless BOTH SIDES of the form are completed and all 3 signature lines are SIGNED

TURN OVER →

PORTABLE DENTAL PROGRAM – INCOME GUIDELINES TO RECEIVE SERVICES
200% of Federal Poverty Level guidelines

You MUST provide your household income to be eligible for free dental care from Miles of Smiles, Inc.

Names of ALL household members	*Gross Monthly Earnings (before deductions)*	*Monthly welfare, child support and alimony*	*Monthly payments from pensions, retirement, Social Security*	*Any other monthly income*
1.	$	$	$	$
2.	$	$	$	$
3.	$	$	$	$
4.	$	$	$	$
5.	$	$	$	$

Signature of Adult Household Member **Date**

I give my informed consent for the dentists and their auxiliary staff to take x-rays and photos of my child's mouth, face and teeth to provide the care the dentist deems necessary for the treatment of his/her oral condition. I will receive information advising me of my child's oral health needs. I also authorize the release of information for any applicable insurance coverage.

Please check any procedure you would **NOT** like completed in our program:

❒ Exam ❒ Cleaning ❒ X-Rays ❒ Sealants ❒ Fillings ❒ Fluoride Application
❒ Stainless Steel Crowns ❒ Pulpotomy ❒ Extractions ❒ Space Maintainers
❒ Nitrous Oxide / Laughing Gas (Not used in schools, Office Use Only)

Signature of Parent / Legal Guardian **Date**

I certify that all of the above information is true and correct and current. I understand that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal Laws.
We are required by law to give you a copy of the HIPPA notice and to obtain your written acknowledgement that you have received a copy of this notice. HIPPA Notice: Can be viewed online at www.milesofsmilesinc.org/facts_and_forms

I, ________________________________, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature Parent / Legal Guardian **Date**

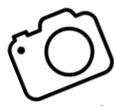

PHOTO RELEASE (Do not sign if you wish to decline)

I authorize Miles of Smiles, Inc. to take photographs my child's teeth, jaws, and face. I understand that the photographs will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc). I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Signature Parent / Legal Guardian **Date**