

## FUTURE SMILES HEALTH HISTORY/CONSENT

Future Smiles is a preventive oral health program that includes a dental cleaning, dental sealants, fluoride varnish applications, and limited locations may offer dental x-rays. Eligible children are CCSD students who are 18 years and younger, uninsured or Medicaid/CHIP enrollees. All restorative dental needs will be referred to your current dental home or partnering community dental office/clinic. This is a five-year commitment to allow for continuation of care.

**Please complete the following so your child can participate in the program. Return forms to your child's teacher.  
DO NOT FORGET TO SIGN. Thank you!**

**YES, I authorize** a public health dental hygienist to assess the permanent molars/premolars of my child and then authorize placement of dental sealants on those teeth that are indicated by staff of Future Smiles, dental/dental hygiene students, and/or volunteer dental hygienists. I also authorize all preventive dental services to include dental cleaning (prophylaxis), fluoride varnish, CalmKIDZ™, Oraspa™ and x-rays of my child's teeth. I agree to accept appointment reminders and other messages on my phone and email, allow my child's image to be used by Future Smiles, to take a satisfaction survey and review of my child's CCSD data for program evaluation and promotion. I agree not to hold Future Smiles or its partners liable for any negative reactions as a result of care received for my child or myself. If applicable I approve the billing of Medicaid/CHIP for services provided.

\_\_\_\_ I agree to allow Future Smiles or another agency to assist me with Medicaid enrollment and referral for dental restorative treatment. (initial for yes)

*Please indicate if you do not want your child to receive any specific services*

- |   |   |
|---|---|
| ____ I do not want my child to receive sealants           | ____ I do not want my child to have fluoride varnish      |
| ____ I do not want my child to have a dental cleaning     | ____ I do not want my child's image used by Future Smiles |
| ____ I do not want my child to have dental x-rays         | ____ I do not want messages left on my phone              |
| ____ I do not want my child to take a satisfaction survey | ____ I do not want my child's CCSD data reviewed          |
| ____ I do not want my child to experience CalmKIDZ™       | ____ I do not want my child to experience Oraspa™         |

**Parent or guardian:** \_\_\_\_\_

**Print name:** \_\_\_\_\_

**SIGNATURE (Must have this)** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Student ID #:** \_\_\_\_\_

Name of child: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Room: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's race:

White/Caucasian _____	African American/Black _____	American Indian/Alaska Native _____	Asian _____
Hispanic _____	Native Hawaiian/Pacific Islander _____	Mixed race _____	Other _____

**\*ALL children can participate in this program whether or not they have dental insurance\***

Please answer the following questions to help us learn about your child and provide the best care possible:

About how long has it been since your child last visited a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all

1. other dental specialists, as well as dental hygienists (please check one).  
6 months-1 year \_\_\_\_\_ 1-3 years \_\_\_\_\_ More than 3 years \_\_\_\_\_ Never been to the dentist \_\_\_\_\_
2. Has your child gone to the dentist for: routine care \_\_\_\_\_ OR emergency care \_\_\_\_\_ (please check one)
3. Is your child experiencing oral pain (toothache, sore gums, etc.)? YES \_\_\_\_\_ NO \_\_\_\_\_
4. Does your child have: Medicaid  Nevada Check-Up (CHIP)?  Private insurance  No insurance   
**Medicaid ID #** \_\_\_\_\_ **Private Insurance Info** \_\_\_\_\_
5. Does your child have an established dentist? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, name of dentist \_\_\_\_\_
6. Has your child ever had a serious health problem? \_\_\_\_\_
7. Did you take your child to a hospital emergency room for a dental \_\_\_\_\_-related emergency this year? YES \_\_\_\_\_ NO \_\_\_\_\_
8. Is there anything we should know about your child prior to treatment? \_\_\_\_\_
9. Is your child on any medications? If YES list: \_\_\_\_\_

10. Does your child have any allergies (e.g., medicine, latex, nuts, etc.)?

Future Smiles | 3074 Arville Street | Las Vegas, NV | 89102 | O (702) 889-3763  
Email: info@futuresmiles.net | Web: www.futuresmiles.net



Funding for services is made possible by a network of generous local and national partners.  
Future Smiles will never send you a bill.

Dear Parents/Guardians,

Future Smiles is a dental hygiene program that focuses on dental disease prevention. Our services are provided at school-based locations serving CCSD students who are from low-income families, uninsured and/or Medicaid/CHIP enrollees. There is no fee to the child or the family for our services, but we do bill Medicaid/CHIP. Your child will be seen by a dental hygienist and will receive one or more of the following preventive services: (1) dental cleaning, (2) sealant, (3) dental x-rays at limited locations and (4) fluoride varnish/topical. 6 to 12-month follow-up care is highly recommended!

A dental sealant is a thin plastic coating that fills in the deep grooves on the chewing part of the tooth. They are easy, painless and will help prevent decay as your child grows.

Fluoride varnish is a protective coating that is painted on the teeth to help strengthen the tooth structure helping the teeth to be more resistant to decay.

A dental cleaning removes all hard and soft material that forms on the child's teeth. Future Smiles staff will also educate your child on how to properly care for their teeth at home and make good diet choices for a healthy future.



You can find consent forms and current Future Smiles information on our website: [www.futuresmiles.net](http://www.futuresmiles.net)

To take advantage of this great program conducted at the school PLEASE fill out the attached consent form. This is **CONFIDENTIAL** information and allows us to continue serving your child and others in the community.

1. Number of adults living in your household \_\_\_\_\_ Number of children living in household \_\_\_\_\_
2. Monthly income \$ \_\_\_\_\_
3. Does your child receive free and reduced lunch at school? YES  NO
4. What is your highest level of education?  
Less than high school \_\_\_\_\_ High school diploma/GED \_\_\_\_\_ Some College \_\_\_\_\_ Bachelor's degree or higher \_\_\_\_\_
5. Does your child live with the following family member(s)?  
Single parent/mother \_\_\_\_\_ Single parent/father \_\_\_\_\_  
Both parents \_\_\_\_\_ Other \_\_\_\_\_
6. What is your source of income? (you may select more than one option)  
Employment \_\_\_\_\_ Unemployment insurance \_\_\_\_\_ Social Security/SSI \_\_\_\_\_  
TANF \_\_\_\_\_ Retirement/Pension \_\_\_\_\_ No income \_\_\_\_\_  
Other \_\_\_\_\_
7. If employed, are you: Full-time  Part-time

8. What is your current housing?

Own

Rent

Homeless

Other

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

-----FOR OFFICE USE ONLY-----

LOCATION EPOD

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<b>MOBILE</b>	BA	BAI	BE	CH	DI	FH	GI	KC	MC	PE	RP	WH	WI	WY	Other:

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