☐ **Please check here if you DO NOT want your child to be seen at his time.**

Smiles for New Mexico Kids
(505) 553-3607 • www.smilesforkidsmobile.org
E-mail: mobile@smilesforkidsdentistry.com
mobile office pediatric dental

School Name
Nombre de la Escuela

CHILD'S FIRST/NOMBRE | CHILD'S LAST/APELLIDO | DATE OF BIRTH/FECHA DE NACIMIENTO

SEX: ☐ FEMALE ☐ MALE GRADE:_____

TEACHER'S NAME/NOMBRE DEL MAESTRO/A: | Ethnicity (Optional) Origen etnico

PARENT FULL NAME/NOMBRE DEL PADRE | CONTACT PHONE NUMBER/NUMERO DE TELEPHONO

ADDRESS/SEÑAS | CITY | STATE | ZIP

EMAIL ADDRESS

PAYMENT OPTIONS:

☐ **OPTION 1:Medicaid**
Child With **Medicaid** coverage

Medicaid ID# / Numero de Medicaid:

☐ **OPTION 2: Private Dental Ins.**
Child With **Private Insurance**/Seguro Privado

Insurance Name/Nombre de Segura:

Policy Holder's Name/& Date of Birth:
Nombre de Asegurado & Fecha de Nacimiento

Insured's full SSN or ID/Numero do Identification de Asegurado:

☐ **OPTION 3:** **Check/Cash**
Cheque/Dinero

Please enclose cash/checks payable to:
por favor fijan dinero/ cheque y retornar a la enfermera

SMILES FOR NM KIDS
and return to school nurse

All 4 recommended by ADA
Los 4 estan recomendidos por ADA

☐ Cleaning & Exam Limpieza y Examen	$60.00
☐ Fluoride/Flour	$15.00
☐ X-rays/Rayos-X	$25.00
TOTAL	**$100.00**

☐ **OPTIONS 4:** **Dental Grant**
Beca Dental

Please submit my child for a dental grant.
Por favour presenten mi hijo por una beca dental.

(Limited number of grants available at each school.
Grants cover exam, cleaning, and fluoride only.)
(El numero de becas esta limitado en cada escuela.
Las becas cubren solo examen, limpieza, y fluoro.)

If my child has cavities, I opt to have:
(Please check one below)

☐ Treatment performed by Smiles for NM Kids on the mobile clinic. I give my consent to Smiles for NM Kids to administer anesthetic and/or laughing gas if needed.

☐ Smiles for NM Kids can call me at _____ to discuss follow-up treatment.

☐ Treatment performed by our own dentist, no follow up care done by Smiles for NM Kids. X-rays and charts available for you dentist upon request.

Si mi hijo(a) tiene canes, prefiero:
(selecclone una delas opciones)

☐ Que el tratamiento lo realize "Smiles for NM Kids" en la clinica movil.

☐ Que "Smiles for NM Kids" me llame al telefono _____ para discutir las opclines de tratamiento.

☐ Que el tratamineto lo realize nuestro dentist familiar.

Medical History/Historia Medica: (This section must be completed for services to be performed.) Esta section debe de llenarse completamente para recibir servicios.

1.) Is child in good health?/Esta el niño en buena salud? _____ ☐ Yes ☐ No

2.) Has child had a history of diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, or ear infection? (circle all that apply) ☐ Yes ☐ No
Ha sufrido el niño la de diabetes, problemas de Corazon, asma, infeccion de riñon, fiebre reumatica, dolor de nuelas, o infection de oidos? (marquee todo lo que aplica)

3.) Has child had any serious illness, siezure, or dizziness? When and/or what?
Ha tenido el niño alguna enfermedad seria, ataque, marreos, vertigo? Cuando y Cual? _____ ☐ Yes ☐ No

4.) Is child receiving medication? What? Why? Esta tomando el niño alguna medicina? Cuál? Porque? _____ ☐ Yes ☐ No

5.) Is child allergic to penicillin, antibiotics or other drugs? Es el nino alergico a la penicillna, antibioticos o otras cosa? _____ ☐ Yes ☐ No

6.) Does child have any other allergies?/ Tiene el nino cualquier otra alergia? _____ ☐ Yes ☐ No

7.) Is child subject to profuse bleeding?/ Es el niño propenso a sangrar profundamente? _____ ☐ Yes ☐ No

8.) Is child subject to nervous disorders?/ Es el niño propenso a desordenes nerviosos? _____ ☐ Yes ☐ No

I certify that the above information is complete and accurate. As the parent or guardian of the patient noted above, I do hereby request and authorize the Dental Staff to perform necessary dental services for my child, including cleaning, exam, necessary x rays, sealants, nitrous oxide (laughing gas), administration of anesthesia, restorations, crowns, pulp treatment, extractions and/or any services recommended by the Provider. I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on my child's teeth that were not discovered during initial examination. I give my permission to the Provider to make any/all changes and additions as necessary with my informed consent. THIS CONSENT FORM SHALL REMAIN IN EFFECT FOR THE ENTIRE 2021 2022 SCHOOL YEAR AND MAY INCLUDE BOTH FALL AND SPRING VISITS.

PARENT SIGNATURE: X_____ FIRMA DEL PADRE: X_____

If you need assistance filling out this form, please contact us at: 505-553-3607

Contact Information: Mobile Dental Unit: 505.553.3607
505.892.9010 (West Abq.) 505.299.9606 (East Abq.)
505.884.KIDS (Rio Rancho) 505.873.4444 (South Valley)