

PARENT OR GUARDIAN PERMISSION FORM

DILLON SMILES FOR A LIFETIME

*Please fill out, sign, and return to your child’s school nurse or Smiles office IMMEDIATELY.*

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male\_\_\_\_\_\_\_\_\_\_\_ Female\_\_\_\_\_\_\_\_\_\_\_\_

 (First) (Middle) (Last)

Check one: African American \_\_\_\_\_\_\_\_ Caucasian \_\_\_\_\_\_\_\_ Hispanic: \_\_\_\_\_\_\_\_ Asian \_\_\_\_\_\_\_ Indian\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Mail delivery address) (City, State, Zip)

Parent or Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father’s Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I freely give my permission for my child to receive services from Dillon Smiles for a Lifetime during the school year. Treatment will

Include all standard dental procedures and may involve “numbing the mouth” with a local anesthesia and / or use of nitrous oxide.

I understand that my child will be transported, by the Dillon Four School District, for a professional dental exam and / or treatment.

Treatment is provided by a S. C. licensed dentist and dental professionals.

I further release from liability the staff of Dillon Smiles for a Lifetime and Dillon Four School District. I understand that treatment is

Given to us voluntarily and I have freely accepted.

I authorize release of any information to process my dental claims to Medicaid or my private insurance company. I authorize and direct

payment to Dillon Smiles for a Lifetime. I request and authorize the release of any information concerning, the above child for proper treatment and care. I understand the Dillon Smiles for a Lifetime Notice of Privacy is posted at the dental center and a summary is printed on the reverse side of this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(DATE) (PARENTAL SIGNATURE)

IF CHILD HAS MEDICAID:

My child has Medicaid (list the Medicaid number) # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YOU HAVE PRIVATE INSURANCE:

*I hereby authorize payment directly to Dillon Smiles for a Lifetime of the group insurance benefits otherwise payment to me.*

SIGNARURE OF POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security / ID # \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address to mail claim: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Co. Telephone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE COMPLETE HEALTH HISTORY ON REVERSE SIDE OF FORM**