

Jefferson County *Give Kids a Smile*

Dear Parent/Guardian,

Thank you for your interest in Jefferson County *Give Kids a Smile* 2011, a dental clinic providing dental care for children, ages 5 to 18, at no cost to the parent/guardian.

Attached are forms for you to fill out for your child. Please complete a packet for each child you are wishing to enroll in the program.

Please fill out all information and attach proper income verification in order for your child/children to be eligible for this dental program and potentially receive an appointment. Please attach a copy of your 2010 Tax Return that reflects your household income. If your child receives Medicaid, please attach a copy of his/her Medicaid card.

Eligibility Guidelines for Patients:

- Child must be 5 to 18 years (child must be 5 by March 1, 2011)
- Child must not have any form of private dental insurance (Medicaid does not count as private insurance) **AND** must qualify for the 2011 Federal Free + Reduced Lunch Program

OR

- Child must have a current Medicaid card (Harmony, HealthCare USA, Molina, Missouri Cares, MC+)

**Priority will be given to children who have no dental insurance or Medicaid coverage and who qualify for the Federal Free and Reduced Lunch Program, but select slots will be held for children with Medicaid. Please apply immediately even if your child has Medicaid.*

Please contact me if you have any questions.

Sincerely,

Jessica Rhodes

Jefferson County *Give Kids a Smile* Coordinator

Jefferson County Community Partnership

Phone: (636) 464-5144, x20, E-mail: community@jccp.org





**Jefferson County Give Kids a Smile
Patient Application
2011**

Please return to: Jefferson County
Community Partnership
Attn: Jessica Rhodes
1671 Marriott Lane, Barnhart, MO 63012

FOR OFFICE USE ONLY	
Has Income Been Verified?	
___ Yes	___ No
Date Verified _____	
Initial _____	

**Please complete a separate form for each child.*

Child's Full Name: _____

Date of Birth: _____ Gender: _____ Race/Ethnicity: _____

Address: _____ City: _____ Zip: _____

Parent/Guardian's Name: _____

Daytime Phone: _____ Home Phone: _____ Cell Phone: _____

Please answer the following questions:

- Will you be enrolling any siblings of this child in the *Give Kids a Smile* program?
Yes No
If yes, what are their names? _____
- What type of Dental Insurance does your child have?
Medicaid *None* *Other:* _____
- Has this child ever seen a dentist? Yes No
If yes, when was the last time? (Please circle)
1-6 months 7-12 months More than a year ago
- Has the child received services at Give Kids a Smile in the past? Yes No
- Has the child received services from the Dental Van (*Smiles to Go*)? Yes No
If yes, how long ago was the child seen? (Please circle)
1-6 months 7-12 months More than a year ago
What treatment was received on the dental van? _____
- Is this child in immediate need of dental services? Yes No
(i.e. broken tooth, infection, pain, etc.)
- Does the child have transportation to and from the dental clinic? Yes No
- Could you bring your child to more than one appointment?* Yes No



**Jefferson County Give Kids a Smile
Health History/Consent for Treatment 2011**

How Did You Hear About Us? (Please identify the friend, school, church, organization)

Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Email: _____ FAX#: _____
Office Phone: _____

Information About Child

First Name _____ M.I. _____ Last Name _____

Date of Birth: _____ Gender: _____

Home Address: _____
Street City Zip Code

Phone: _____ Parent/Guardian Cell/Mobile Phone _____

Is Child Medicaid Eligible? Yes No

If yes, what is the coverage? HealthCare USA Molina Harmony
(Please check) MC+ (Red Card) Missouri Cares Other _____

Child Lives With – Check here if same as above

First _____ MI _____ Last _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____

IN CASE OF EMERGENCY CONTACT on the day of service at the clinic

First _____ MI _____ Last _____

Address _____

City: _____ State _____ ZIP _____ Phone _____

Child's Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

Does your child have or has your child had . . .

Asthma Yes No

Heart Murmur Yes No

Diabetes Yes No

Seizures Yes No

Rheumatic Heart Disease Yes No

Congenital Heart Disease Yes No

Bleeding Problems Yes No

Does your child have any allergies? Yes No

What Allergies? _____

Is your child allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other – Please explain _____

Is your child taking any medications, pills or drugs? Yes No

If yes, please explain _____

Has your child had any other serious illnesses or any operations? Yes No

What illness(es) or operation(s)? _____

Has your child been hospitalized? Yes No

If yes, please explain _____

Has your child had a serious neck or head injury? Yes No

If yes, please explain _____

Does your child have or has he/she had any of the following? (Please check all that apply)

- AIDS/HIV Positive Chest Pain Frequent Headaches Irregular Heartbeat
- Scarlet Fever Anemia Cold/Sores/Fever Blisters Genital Herpes
- Kidney Problems Shingles Angina Congenital Heart Disorder Hay Fever
- Leukemia Sickle Cell Disease Artificial Heart Valve Convulsions
- Heart Attack Liver Disease Sinus Trouble Artificial Joint
- Cortisone Medicine Heart Murmur Low Blood Pressure Spina Bifida
- Asthma Diabetes Heart Pace Maker Lung Disease
- Stomach/Intestinal Disease Blood Disease Epilepsy or Seizures
- Heart Trouble Mitral Valve Prolaps Stroke Blood Transfusion
- Excessive Bleeding Hemophilia Pain in Jaw Joints Swelling of Limbs
- Breathing Problems Excessive Thirst Hepatitis A Parathyroid Disease
- Thyroid Disease Bruises Easily Fainting Spells/Dizziness Hepatitis B or C
- Psychiatric Care Tonsillitis Cancer Frequent Cough Herpes
- Radiation Treatments Tuberculosis Chemotherapy Frequent Diarrhea
- High Blood Pressure Recent Weight Loss Tumors or Growths Hives or Rash
- Renal Dialysis Ulcers Rheumatic Fever Yellow Jaundice Ear Tubes
- Recurrent Ear Infections Hearing Loss

Has your child ever had any serious illness not listed above and/or is there anything else we should know about the health of your child? Yes No

If yes, please explain _____

Is your child under a physician's care now? Yes No

If yes, please explain _____

I give consent for my child to participate in the preventive and restorative dentistry program conducted by the program known as Give Kids A Smile. To the best of my knowledge, the medical history questions have been answered correctly and accurately. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Give Kids a Smile of any changes to my child's medical status. I allow my child to receive local anesthetic (numbing of the teeth), dental treatment, antibiotics, and analgesics (Tylenol, Ibuprofen) with appropriate instructions if deemed necessary by the treating dentist, and to be photographed while at the clinic, understanding that the photos may be used in future educational material. Our dental clinic will honor the rights of patients regarding their protected health information with rare exceptions that must use and disclose only as much information needed to accomplish the intended dental treatment.

Signature _____ **Date** _____

Name of Parent/Guardian (Printed) _____