Great Lakes Bay Health Centers

SMILES ARE EVERYWHERE

Mobile Dental Program

989-921-4393

THE DENTAL BUS IS COMING TO YOUR CHILD'S SCHOOL!

Patient Name: _____ Grade: _____ Teacher Name: _____

Birth Date: ____/_____/____ Gender: ☐ Male ☐ Female Email Address: _____

Address: _____ City: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Race: ☐ White ☐ Black/African American ☐ Native Hawaiian ☐ American Indian/Alaska Native

☐ Asian ☐ Other Pacific Islander ☐ More than one race ☐ Refuse to report

Are you Hispanic/Latino?: ☐ Yes ☐ No ☐ Refuse to Report Is English your primary language?: ☐ Yes ☐ No

Are you or a family member a Migrant or Seasonal Farmworker?: ☐ Yes ☐ No

Guardian Information

Name: _____ Phone Number: _____ Birthdate: ____/_____/_____ Relationship to Patient: _____

Emergency Contact

Name: _____ Phone Number: _____ Relationship to Patient: _____

Dental Insurance: _____ Medical Insurance: _____ Subscriber Name: _____

Insurance ID #: _____ Subscriber Birthdate: ____/_____/____ Relationship to Patient: _____ Subscriber Employer: _____

Our Federal Funding requires we ask income of all our patients. Your name/identity is not used in any of our reports.
This information also helps us determine if you qualify for our payment assistance program (Sliding Fee).

Household Income $_____ ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annual

How many people in the household does this income support?: _____

In order to qualify for a Sliding Fee, you must:

1. Complete the "Application for Sliding Fee Program" below.
2. Write all the names and ages of persons residing in the household. **(Signature required)**

To be completed by Staff only.
GLBHC Sliding Fee Category: _____
Staff Signature: _____
Date: ___ /___ /___
☐ Mobile Slide ☐ Standard Slide
GLBHC Site: Mobile

Application for Sliding Fee Program

Total 'Gross Annual' Household Income from all Sources: $_____
(Including Wages, Social Security, Public Assistance, Unemployment, Pension Payments, Alimony, Child Support or Other Cash Income)

Name Persons Residing in Household	Age	Name Persons Residing in Household	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

******Total Number of People in Household _____

I declare that this information relative to my total household income and family size as stated above is true and factual.

Head of Household/Authorized Person Name: _____

PLEASE SIGN HERE Head of Household/Authorized Person Signature: _____ Date: ____/_____/____

Medical History (Please check Yes or No)

Allergies (other) type: _____ ☐ Yes ☐ No Asthma: ☐ Yes ☐ No Seizures: ☐ Yes ☐ No

Allergies (medications): _____ ☐ Yes ☐ No Diabetes: ☐ Yes ☐ No Other Medical Conditions/Medications: _____

Heart Problems type: _____ ☐ Yes ☐ No Is pre-medication needed for dental procedures?: ☐ Yes ☐ No

By signing this consent form and selecting "YES", I certify that I am the legal guardian and legal custodian of the student named above. I give my consent for the above named student to receive all services, listed on the front of this consent form, provided by Great Lakes Bay Health Centers Mobile Dental Program. I understand that treatment may be obtained at the patient's dental home rather than the mobile dental facility and that obtaining duplicate services at a mobile dental facility may affect benefits that he or she receives from private insurance, a state or federal program, or other third-party provider of dental benefits. I authorize GLBHC's Mobile Dental Program to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both GLBHC and my child's dentist to exchange health care information for the purpose of continuity and coordination of care. By selecting "NO" and signing this form, my child will not be treated. I understand that I may withdraw my consent for services upon written notice to GLBHC's Dental Department at any time. Make sure to read and complete both sides of this form before signing.

☐ Yes, I give permission to have my child receive dental treatment from GLBHC's Mobile Dental Program.

☐ No, I would not like my child to receive dental treatment from GLBHC's Mobile Dental Program.

Patient/Guardian Name: _____

PLEASE SIGN HERE Patient/Guardian Signature: _____ Date: ____/_____/____

Great Lakes Bay Health Centers

SMILES ARE EVERYWHERE
Mobile Dental Program
989-921-4393

No insurance? Please call us at (989) 921-4391 and we can connect you with a Community Health Worker.

Dear Parent/Guardian:

Great Lakes Bay Health Centers Mobile Dental Program, Smiles Are Everywhere, will be coming to your child's school to provide preventive dental treatment *(dental cleanings, oral exams, fluoride treatments, and (sealants—by age)*.

Name of School: _____ Date(s): _____

Smiles Are Everywhere is Great Lakes Bay Health Centers Mobile Dental Program. With three state of the art mobile dental units, we have the ability to provide preventive dental services to school-age children. GLBHC's newest mobile dental unit is wheelchair accessible. It has a built-in lift allowing increased access to the dental services provided within the mobile unit. *Please call our offices in advance if your child will be in need of the wheelchair lift; we will ensure the correct mobile unit arrives at your school.* The program staffs seven hygienists and one dentist. Our school based dental staff provides **dental cleanings, oral exams, fluoride treatments, and (sealants - by age)** to various Head Start and school-aged students throughout the Great Lakes Bay Region and beyond.

Convenience is key; as the dental services are provided right on school grounds. If it wasn't for this much needed program, many students would not receive dental care! To encourage follow-up dental care, patients are referred to their family dentist or to one of GLBHC's six dental centers where they are able to establish a dental home.

Everyone is welcome *at Great Lakes Bay Health Centers regardless of insurance coverage*. We accept most forms of insurance. ***Patients without insurance may be eligible for a nominal fee of $20.00*** based on household income and family size. Those that have insurance may also qualify for a discount as well. In order to qualify for lower fees, patients with and without insurance are asked to apply for a sliding fee discount. *See reverse side of this form - Sliding Fee Application. Please send a copy of your current insurance card.*

****
If your child has received treatment from their dental home, obtaining duplicate services could affect their dental benefits if also received on the mobile unit.
****

A **dental report card** will be sent home with your child informing you of the treatment they have received, as well as if there are any concerning dental issues. We encourage you to promptly schedule an appointment with your child's dentist or at one of our dental centers (listed on report card) if further treatment is necessary.

As a reminder, when you sign your child up to receive preventive dental care on Great Lakes Bay Health Centers Dental Bus; they will receive the following services: *dental cleanings, oral exams, fluoride treatments, and sealants - by age*.

****Please return consent form to your child's teacher. Thank you.****

Respectfully,

Oral Health Coordinator
Smiles Are Everywhere Mobile Dental Program
501 Lapeer Avenue
Saginaw, MI 48607
Office: (989) 921-4393
24 Hours Emergency Number (989) 776-5394

Please complete the consent form and the reverse side of this form.
Signatures required.