Upper Great Lakes Family Health Center

School-Based Dental Registration Form

General Information (Please Print)

Child's Name: ______________________________ Date of Birth: ______________

First   Middle Initial   Last   MM/DD/YYYY

Address: ____

Street   City   State   Zip Code

School Name: ______________________________ Grade: ______________

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ White   Gender: ______________

☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino

Parent's/Guardian's Name: ______________________________ Phone Number: ______________

Health Information

Does your child have a serious health problem? If yes, please explain: ______________ ☐ Yes ☐ No

____

Does your child have asthma? ☐ Yes ☐ No

Is your child presently taking medication? If yes, please list: ______________ ☐ Yes ☐ No

____

Have you ever been told by a dentist or physician that your child needs to take antibiotics (Amoxicillin or Clindamycin) before dental care? ☐ Yes ☐ No

Is your child allergic to any medications? If yes, please list: ______________ ☐ Yes ☐ No

____

Is your child allergic to latex? ☐ Yes ☐ No

Has your child ever been examined by a dentist? If yes, date of last exam: ______________ ☐ Yes ☐ No

What was the reason for the visit? ______________________________

Name of your child's dentist, if applicable: ______________________________

During the last 12 months, was there a time when your child needed dental care and was unable to receive dental services? If yes, please explain why: ______________ ☐ Yes ☐ No

____

Referral Information

If it is determined that your child is in need of additional dental care, please indicate where you would like a referral sent:

☐ Upper Great Lakes Family Health Center

☐ Your child's current dentist

A duplication of services could result in an out-of-pocket expense which is the patient's/parent's responsibility.

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Payment Information

Co-pays, deductibles and services not covered by insurance plans will be billed to the parent/guardian. Reduced fees may be available through UGL's Sliding Fee Program for qualified individuals.

Does your child have dental insurance? If yes, please enter the appropriate information below. ☐ Yes ☐ No

Medicaid Information:

Child's 10 digit Medicaid Recipient ID #: ____________________

OR

Other Insurance:

Name of Insurance Company: ____________________

Address of Insurance Company: ____________________
Street

____
City **State** **Zip Code**

Phone Number of Insurance Company: ____________________

Policy Holder's Information:

Name: ____________________

Address: ____________________
Street

____
City **State** **Zip Code**

Date of Birth: ____________________ Social Security #: ____________________
MM/DD/YYYY

Member ID #: ____________________

Services Offered

I have read and understand the Silver Diamine Fluoride information and give permission for my child to receive the following services:

- ☐ Oral Health Assessment
- ☐ Cavity Exam
- ☐ Determine Risk of Future Cavities
- ☐ Oral Health Education/Instruction
- ☐ Teeth Cleaning
- ☐ Fluoride Varnish
- ☐ Sealants (after permanent molars are visible)
- ☐ Silver Diamine Fluoride (SDF) on all teeth
- ☐ Silver Diamine Fluoride (SDF) on back teeth only (due to discoloration)

By signing below, I certify that I have read all information is true and correct to the best of my knowledge.

Parent's/Guardian's Name (Printed): ____________________

Parent's/Guardian's Signature: ____________________

Date: ____________________