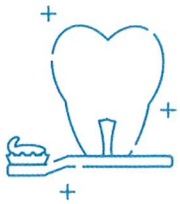
DETROIT MERCY DENTAL CENTER

TITANS *for* TEETH
MOBILE CLINIC



The dental clinic is coming soon to Elmwood!

Sign up by September 25th

Detroit Mercy Dental is providing dental services to Elmwood. Students can receive services during the school day during the weeks of:

- October 1st – 3rd
- October 8th – 10th

Dental services available:

- Dental screenings
- Dental Cleanings
- Sealants
- Fluoride Treatments
- Referrals

Did you know?

Cavities are one of the most common chronic diseases of childhood in the United States. Children and adults should visit a dentist every six months for a cleaning and oral exam.

Parents & Guardians,

Sign up by September 25th

https://form.jotform.com/udmdentalcp/tftmc

Want a chance to win an Amazon Fire Tablet?

Submit the form and you will be entered to win! You can submit the form even if you do not want your child to receive dental services - just select NO in response to the first question.

Questions? Contact April Kotermanski, Mobile Program Manager, at (313) 494-6645

DETROIT MERCY DENTAL CENTER

TITANS *for* TEETH
MOBILE PROGRAMS

Dental Consent and Medical History

Infant Oral Health Program
- Knee to Knee Screening
- Fluoride Treatment
- Oral Hygiene Education

Macomb County Oral Health Program
- Dental Screenings
- Teeth Cleaning
- Fluoride Treatment
- Sealants
- Oral Hygiene Education,
- Referrals (as needed)

Titans for Teeth Mobile Clinic
- Dental Exam & X-rays
- Teeth Cleaning
- Fluoride Treatment
- Sealants
- Fillings, Extractions, Pulpotomy
- Oral Hygiene Education
- Referrals (as needed)

Dear parent or guardian: The University of Detroit Mercy School of Dentistry's Titans for Teeth Mobile Programs (TFTMP) is pleased to provide dental care at your child's school during school hours. Dental treatment will be provided only as needed.

The treatment will be carried out by dental students under supervision of a licensed dentist and/or dental hygienist faculty. Nitrous Oxide (happy air) and/or local anesthetic (tooth numbing medicine) may be used for some procedures. Please fill out this form and return to school, if you like your child to receive these services. If you have any questions about the program, please contact our Mobile Program Coordinator at dentaloutreach@udmercy.edu.

WOULD YOU LIKE YOUR CHILD TO RECEIVE DENTAL SERVICES IN THE TFTMP? ☐ YES ☐ NO

If you checked `YES`, please complete the information below: PLEASE PRINT CLEARLY IN INK

School Name: _____

CHILD'S INFORMATION

Child's Last Name: _____

Child's First Name: _____

M.I.: _____ Birth Date: _____/_____/_____ Age: _____

Male ☐ Female ☐ Grade Classroom No: _____

☐ African American
☐ American Indian/ Alaska Native
☐ Asian
☐ Caucasian
☐ Hispanic
☐ Native Hawaiian or Pacific Islander
☐ Other
☐ Unknown

Address_____

City_____ Zip Code: _____Child's Social Security #: _____

Parent/Guardian First and Last Name:

_____

M.I.: _____ Parent's Social Security #: _____Relationship to Student/Patient: _____

( ) _____ - _____Home Telephone Number ( ) _____ - _____Work Telephone Number

( ) _____ - _____Cellular / Pager Number

Name of Emergency Contact: _____

( ) _____ - _____Home Telephone Number

Email: _____

TURN OVER

INSURANCE INFORMATION

☐ Child has MEDICAID: Enter Child's 9 or 10-digit Medicaid Recipient ID Number: _____

☐ Child has Private Dental Insurance *(for those with private insurance. Parent/guardian is responsible for deductibles and co-pays.)*

Insurance Plan: _____

Insurance ID Number: _____ Group Number: _____

Subscriber's Name (parent/guardian): _____

Subscriber's Birth Date: _____ / _____ / _____ Subscriber's Social Security #: _____

☐ Child has no dental insurance:

I will pay the discounted fee for the services provided to my child in the TFTMC. ☐ **Yes** ☐ **No**

MEDICAL HISTORY

When was your child's last dental visit? ☐ Within the last 12 months ☐ More than 12 months ☐ Never been to a dentist

What services has your child received during last visit? _____

If your child goes to a dentist, please provide name and phone number:

_____ ( ) _____ - _____

My child's dental visits have been a good experience.	☐ Yes	☐ No
Recent dental problems	☐ Yes	☐ No
Does your child have Asthma?	☐ Yes	☐ No
Does your child have learning or emotional impairment?	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Blood disorder / anemia	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No
Vision problem	☐ Yes	☐ No
Hearing problem	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Hospitalization	☐ Yes	☐ No
Does your child have Allergies (medication, latex or food)?	☐ Yes	☐ No

What is your child allergic to?

Taking daily medication(s) ☐ Yes ☐ No

If yes, name of medication(s), dosage & directions (i.e., albuterol): _____

Condition for medication(s) (i.e., asthma, allergies, ADHD, eczema):

_____

Are medications at the school? ☐ Yes ☐ No

If not where are they? _____

Has your child had any serious health conditions not mentioned above? ☐ Yes ☐ No

Describe: _____

Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? ☐ Yes ☐ No

Please explain any Yes answer(s): _____

_____

Please provide the name and number of your child's doctor:

( ) _____ - _____

1. I am the legal guardian of the child. I have read and understand the information on this form. This form is to obtain my consent for dental treatment for my child. By signing, I give permission for my child to receive dental treatment from the TFTMP.
2. I understand that these services can be obtained at the office of my child's dentist rather than at the TFTMP and may affect benefits that my child receives from private insurance, a state or federal program, or other third-party provider of dental benefits.
3. I have answered every question above completely and accurately. I will inform the TFTMP of any change in my child's health and/or medications.
4. I understand that the TFTMP will bill my child's private insurance or Medicaid if available and that I will be required to provide my insurance information to receive the services. If my child has NO dental insurance, there will be a discounted flat fee to pay for the services.

Signature of Parent/Guardian :

_____ Date _____ / _____ / _____

FORM MUST BE FILLED OUT COMPLETELY IN ORDER FOR YOUR TO CHILD TO RECEIVE SERVICES.