northlakes COMMUNITY CLINIC

northlakesclinic.org

SUPERIOR SMILES PERMISSION SLIP

❒ **Yes!** I give permission for my child to participate.

❒ **No.** I do not want my child to participate. Why? (optional) _____

Child's Legal First Name: _____ **Last:** _____

Circle: **M / F** **DOB:** _____ **Parent/Guardian Phone #:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Please indicate if you need help finding a dental clinic for your child/children: ❒ Yes ❒ No

RACE/ ETHNICITY (select all that apply): ❒ American Indian/Alaskan Native ❒ Asian ❒ Black/African American ❒ Hispanic/Latino ❒ Native Hawaiian/Pacific Islander ❒ White ❒ Other

What type of **DENTAL INSURANCE** does your child have? **NOTE**: No child will be refused services based on their insurance status.

❒ Forward Health/ BadgerCare/ MA FH ID#: _____

❒ Private Insurance (i.e. Delta, Cigna) ❒ No Insurance

School: _____ Teacher: _____ Grade: _____

Dentist / Dental Clinic: _____

Please answer the following questions about your child.

Does your child:

1. Take medicine prescribed by a doctor? **Y / N** If yes, what kind? _____
2. Need or use more medical care than other children the same age? **Y / N**
3. Have trouble doing things most children the same age can do? **Y / N**
4. Need or get special therapy such as physical, occupational, or speech? **Y / N**
5. Need counseling or treatment for behavioral or emotional condition or delays in walking, talking, or activities other children the same age can do? **Y / N**
6. If you marked yes above, has this condition lasted or is expected to last more than 12 months? **Y / N**
7. Have any allergies? (i.e. medications, food, latex) **Y / N** Please list: _____
8. Has your child ever been seen by a dentist? ❒ Yes, within one year ❒ Yes, over one year ago ❒ Never

HOUSEHOLD INFORMATION:

Because our clinic is funded partially by a grant from the federal government to see under/uninsured, we are required to collect household information. This will not affect your child's eligibility in this program, and is confidential.

Number of Adults: _____ Number of Children: _____

Annual income - please estimate your gross income including any wages, child support, alimony, disability, SSI, unemployment, etc:

❒ $0-14,000 ❒ $14,001-$18,000 ❒ $18,001-21,000 ❒ $21,001-25,000 ❒ $25,001-29,000 ❒ $29,001+

I understand there is no fee assosicated with this service. I authorize NorthLakes Community Clinic, acting as the dental adminstrator for Superior Smiles program, to bill my Forward Health Plan/BadgerCare/MA if applicable and receive payment for dental services performed. (If you receive a bill in error please contact our office.) I acknowledge that I am able to exercise my rights under HIPAA of 1996 to access the privacy policy of NorthLakes by visiting their website at www.northlakesclinic.org and that all information shared here is confidential.

PARENT/GUARDIAN SIGNATURE **PRINTED NAME** **DATE**

OFFICE USE ONLY: FH ____ D ____ DS ____ S ____ SC ____ *NO. 27-115*