FREE DENTAL CARE

Miles of Smiles

LEVEL UP KIDS

PORTABLE DENTAL PROGRAM OF LEVELUP KIDS, INC.
5416 NE Antioch Rd • Kansas City, MO 64119 • 816.413.9009

TODAY'S DATE: _____

CHILD'S INFORMATION

Child's Name: _____ Child's Birthday: _____ Child's Age: _____
Child's Address: _____ City: _____ State: _____ Zip: _____
Social Security Number: _____ Sex: MALE / FEMALE Language Spoken at Home: _____
Race (circle which apply): Caucasian American Indian African American Asian Hispanic Other: _____
School: _____ Grade: _____ Teacher: _____
Physician's Name: _____ Physician's Phone #: _____

MEDICAID / INSURANCE INFORMATION

Child's Medicaid #: _____ Plan Information: _____
Private Insurance (circle)? YES or NO If YES, which plan? _____

PARENT / GUARDIAN INFORMATION

Parent / Guardian Name: _____ Relationship to Child: _____
Parent / Guardian Date of Birth: _____ Social Security #: _____
Address (if different from child): _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____
Place of Employment/Occupation: _____

MEDICAL / DENTAL HISTORY

PLEASE CHECK any of the following that your child had or presently has:

□ Heart/Vascular Disease	□ Asthma	□ Kidney Disease	□ Cancer/Leukemia	□ Diabetes
□ Heart Murmur	□ ADHD	□ Rheumatic Fever	□ Liver Disease	□ Bleeding Disorder
□ Pre Med Required?	□ Autism	□ Epilepsy/Seizures	□ Mental Disability	□ Physical Disability
□ Seeing Cardiologist? If so, phone #: _____			□ Other: _____	

CHECK any of the following that your child is **ALLERGIC** to or has had an adverse reaction to:
□ Aspirin □ Local anesthetic □ Penicillin □ Latex (balloons, gloves, rubber, etc.) □ Erythromycin
□ Other: _____

Is your child taking medications? □ Yes □ No If YES, please list medications and reason for taking: _____

Has your child ever seen a dentist before? □ Yes □ No If yes, who? _____ When? _____
Does your child have any dental pain now? □ Yes □ No If yes, how long? □ Days □ Weeks □ Months

We will be unable to see your child unless BOTH SIDES of the form are completed and all 3 signature lines are SIGNED

TURN OVER →

INCOME GUIDELINES TO RECEIVE SERVICES
200% of Federal Poverty Level guidelines

You MUST provide your household income to be eligible for free dental care from LevelUp Kids, Inc.

Names of ALL household members	*Gross Monthly Earnings (before deductions)*	*Monthly welfare, child support and alimony*	*Monthly payments from pensions, retirement, Social Security*	*Any other monthly income*
1.	$	$	$	$
2.	$	$	$	$
3.	$	$	$	$
4.	$	$	$	$
5.	$	$	$	$

Signature of Adult Household Member **Date**

I give my informed consent for the dentists and their auxiliary staff to take x-rays and photos of my child's mouth, face and teeth and to provide the care the dentist deems necessary for the treatment of his/her oral condition. I will receive information advising me of my child's oral health needs. I also authorize the release of information for any applicable insurance coverage.

Please check any procedure you would **NOT** like completed in our program:

□ Exam □ Cleaning □ X-Rays □ Sealants □ Fillings □ Fluoride Application
□ Extractions □ Space Maintainers □ Stainless Steel Crowns □ Pulpotomy
□ Nitrous Oxide / Laughing Gas (Not used in schools, Office Use Only)

Signature of Parent / Legal Guardian **Date**

I certify that all of the above information is true and correct and current. I understand that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal Laws.
We are required by law to give you a copy of the HIPAA notice and to obtain your written acknowledgement that you have received a copy of this notice. HIPAA Notice: Can be viewed online at www.levelupkidsinc.org/patientinfo

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature Parent / Legal Guardian **Date**

PHOTO RELEASE (Do not sign if you wish to decline)
I authorize Miles of Smiles, Inc. to take photographs my child's teeth, jaws, and face. I understand that the photographs will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc). I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Signature Parent / Legal Guardian **Date**