UTOPIA DENTAL CARE, LLC

DOES YOUR CHILD NEED DENTAL SERVICES?

We will be visiting your school soon to offer dental services
Utopia Dental Care, LLC a portable school-based dental clinic, can help!

Now accepting many types of payments:
NEW MEXICO MEDICAID
PRIVATE INSURANCE & PRIVATE PAY
FREE SCREENINGS

Child's First Name _____ Middle Name_____

Last Name_____ (as on insurance or Medicaid care)

Date of Birth _____Child's social security number (for insurance purposes) _____

Male ___ Female___

Full Address_____ City _____ Zip Code _____

Parent/Guardian's Name _____ Home Phone Number _____

Work/Emergency Number _____ School _____

Grade Level ___ Teacher's Name_____

Child's dentist (if any) _____Child's medical doctor _____

Signature of Parent/Guardian _____ Print name of Parent _____ Date _____

My child is enrolled in the following dental insurance program:

__New Mexico Medicaid

__Private Dental Insurance (please provide copy of insurance card)

__Private Pay __ No Dental Insurance

CONSENT FOR TREAMENT
__ YES, provide service for my child
Service Requested:
YES__NO__ Dental exam with x-rays (helps to diagnose cavities between teeth & new teeth developing)
YES__NO__ Dental cleaning with fluoride treatment (fluoride helps reduce the incidence of cavities)
YES__NO__ Dental Sealants (this is resin type coating placed on molars to help prevent cavities. It requires no dental injections)
__YES, provide a FREE screening for my child
____NO, my child sees a dentist. Dentist NAME & Date of last treatment _____

MEDICAL HISTORY
If there is a medical condition which requires pre-medication (including HEART MURMURS) please let us know
YES__NO__ Heart Murmur **If so**, is it resolved per child's medical doctor **YES__NO__**
YES__NO__ Rheumatic Fever **DATE of occurrence _____**
YES__NO__ Asthma **Medication used_____ How often _____**
YES__NO__ AIDS / HIV Virus
YES__NO__ Diabetes **Medication used_____ How often _____**
YES__NO__ Hepatitis **DATE of occurrence _____**
YES__NO__ Mitral Valve Prolapse or Artificial Heart Valve
YES__NO__ Tuberculosi**s DATE of TREATMENT_____**
YES__NO__ Latex Rubber Allergy
YES__NO__ Drug Allergies (**PLEASE LIST) _____**
YES__NO__ Learning Disabilities or Special Needs **(PLEASE LIST) _____**
YES__NO__ Any other health problems **(PLEASE LIST) _____**
YES__NO__ Currently taking any medication **(PLEASE LIST) _____**
YES__NO__ Currently under the care of a Dentist (**PLEASE LIST) _____**

I have read or have had read to me, and I understand the information of this form. All my questions were answered to my satisfaction. I hereby give my permission for the dental professionals of UTOPIA DENTAL CARE, LLC to service my child. This consent shall be valid until withdrawn in writing. Upon completion of such treatment, my child will receive form stating what services were performed and if cavities were found or further dental treatment in needed. Utopia Dental Care, LLC is authorized to furnish any and all records in their possession to any licensed dentist upon request. (Signature) _____

Utopia Dental Care, LLC employees are licensed professionals. We are a Medicaid provider. We are committed to maintain the confidentiality of your child's personal and health information. We are not part of your child's school system. The school system is not responsible for the services Utopia Dental Care, LLC provides.

Dentists include: Anthony Edwards, DDS

IF YOU HAVE ANY QUESTIONS, PLEASE CALL 505-363-3435. DARLY G. BARKLEY, RDH OWNER/COORDINATOR