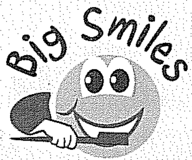
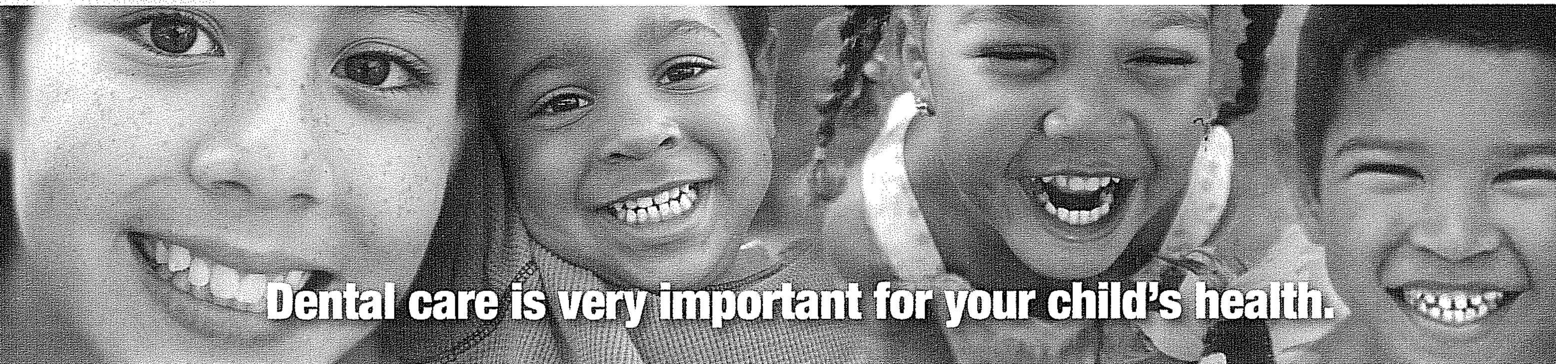


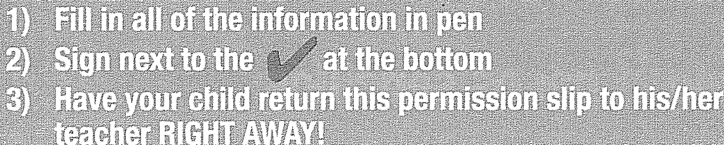
Your child can now receive DENTAL CARE AT *NO COST* TO YOU AT SCHOOL!

Please Return To School TOMORROW!



YOUR CHILD CAN RECEIVE DENTAL CARE AT SCHOOL AND IT IS ABSOLUTELY FREE to you for children covered by Medicaid (MO HealthNet.) We also accept dental insurance and we can even help if you don't have any insurance at all. If your child has a dentist you should continue to arrange dental care through that provider. If you have questions, please call us at (877) 227-9892.

Only 3 easy steps:



1) Fill in all of the information in pen
2) Sign next to the ✔ at the bottom
3) Have your child return this permission slip to his/her teacher RIGHT AWAY!

School: ______________________ District: ______________________

Your Name: ______________________ Relation to Student: ______________________

Student Name: ______________________ Student Date of Birth: ____/____/____

Grade: ________ Track: ____________ Phone: (_____) ____________ 2nd Phone: (_____) ____________

Address: ______________________ City: __________ Zip: __________ Email: __________

Check One: ☐ Child has Medicaid ☐ Child has Private Insurance ☐ Child is Uninsured

Enter Child's 8-Digit Medicaid (MO HealthNet) ID # Below

☐☐☐☐☐☐☐☐

HEALTH HISTORY (CIRCLE "YES" OR "NO" OR LIST) PLEASE NOTIFY US OF ANY MEDICAL HISTORY CHANGES.

Asthma	YES	NO	Kidney Problems	YES	NO
Heart Problems	YES	NO	Blood Disorder	YES	NO
Diabetes	YES	NO	Latex Allergy	YES	NO
Liver Problems	YES	NO	Seizures	YES	NO

Surgeries ______________ Allergies ______________

Medications ______________ Other Conditions ______________

I authorize Dr. Nevin Waters, DDS, PA to provide dental care which may include dental exams, x-rays, cleanings, fluoride, sealants, fillings, crowns, baby teeth root canals and simple extractions of baby teeth at school without my presence unless I withdraw this consent. Services shall be provided by a state licensed general dentist. I authorize and direct Dr. Nevin Waters, DDS, PA to bill and collect payment from any Medicaid, insurance or other third party payer that covers the services provided to this patient, which shall be applied to the patient's benefits. If there will be cost to me, then I will be called first to approve or decline. I acknowledge receiving a notice of privacy practices attached to this consent form.

✔ **SIGN HERE:** ______________________ **DATE:** ______________

Some school districts may release student directory information for us to contact you.
Please check here __ and complete student information above to prohibit this.