



Scan QR code to register today.



LRMC MOBILE DENTAL SERVICES

OFFICE USE/ PT ID # \_\_\_\_\_ SCAN \_\_\_\_\_

Required Fields

GRADE	ROOM #
TEACHER	
LUNCH	
RECESS	SPEC

Rev. 8/2025

Complete in Full- please print clearly in BLUE OR BLACK INK ONLY

School \_\_\_\_\_ After school transportation:  CAR  BUS  AFTER SCHOOL PROGRAM

Student LAST Name [grid]

Student FIRST Name [grid] MIDDLE initial [ ]

DOB: [grid] / [grid] / [grid] Social Security # [grid]

Student Gender  Male  Female Ethnicity:  Hispanic Race:  White  Black  Other

No. in Family: \_\_\_\_\_ Family Annual Income: \_\_\_\_\_ Names of siblings attending school: \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent  Guardian Name: \_\_\_\_\_ Parent DOB \_\_\_\_\_ Parent SSN# \_\_\_\_\_

Parent/ guardian email address \_\_\_\_\_ Best way to contact:  TEXT  CALL  E-MAIL

Emergency Contact Name (Not Parent) \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

PAYMENT INFORMATION- You MUST complete A, B, C, or D

- Homeless
- Dependent of a Migrant or Seasonal Agricultural Worker

A.  Medicaid [grid]  
(child's 10 digit individual #- not plan #)

B.  Dental Insurance - If Child has Insurance and Medicaid, Both sections must be filled in.  
Name of Company \_\_\_\_\_ Phone # \_\_\_\_\_  
INSURANCE ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Name on the insurance card \_\_\_\_\_ SSN# \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

C.  Self-Pay: No dental insurance, please send me a payment letter every time a bus is at my child's school.

D.  I am requesting a Sliding Fee Application to apply for sliding scale rates for my child. I understand that I will be billed accordingly prior to services, and unless payment is received no services will be performed.

SF sent by: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICAL QUESTIONS.....All Questions MUST BE ANSWERED to Receive Services

Has your child seen a dentist? \_\_\_\_\_ If yes, Dentist Name: \_\_\_\_\_ Date last seen: \_\_\_\_\_

Does your child have any current or previous health problems/surgeries?  Yes  No. If so, please list: \_\_\_\_\_

Is your child currently taking any medication? Yes or No. \_\_\_\_\_ If so please list: \_\_\_\_\_  
Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_

Has your child's Medical Doctor advised the need for antibiotics before receiving dental care? \_\_\_\_\_ If yes, name of Doctor: \_\_\_\_\_

Type of water your child drinks:  WELL WATER  BOTTLED WATER  CITY WATER

Does your child have any allergies (including Latex, Penicillin)? \_\_\_\_\_ YES NO Don't know  
If yes please list: \_\_\_\_\_

PLEASE CIRCLE Y or N

- |                           |                 |                      |                           |
|---------------------------|-----------------|----------------------|---------------------------|
| Y N Autism                | Y N Seizures    | Y N ADD / ADHD       | Y N HIV/AIDS              |
| Y N Heart Defect          | Y N Sickle Cell | Y N Hearing Problems | Y N Hepatitis A, B, C     |
| Y N Cancer / Chemotherapy | Y N Asthma      | Y N Diabetes         | Y N Anemia /Blood Disease |

REVIEWED BY DENTIST \_\_\_\_\_ DATE \_\_\_\_\_ REVIEWED BY Hygienist \_\_\_\_\_ DATE \_\_\_\_\_

This CONSENT will remain in effect until I revoke it in writing. YES, I authorize a SC licensed dentist or associate with Miles for Smiles to provide to my child as needed a dental exam, x-rays, cleaning, fluoride, sealants, silver diamine fluoride, extractions, and any restorative work on the mobile dental unit or at their school without my presence. I understand that if my child is not enrolled in Medicaid/Insurance or funded through Miles for Smiles I am financially responsible for services performed. I grant permission for the above child to receive services outlined above on the mobile dental unit that may be located at a school location or community. For the safety and security of patients and staff, Little River Medical Center, Inc. utilizes video surveillance on its mobile dental units. No video or photographs will be released without the explicit consent of the patient/parent/guardian. If you have questions regarding the use of the video surveillance equipment, please contact LRM's Compliance Office at 843-663-8002

PARENT / GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_