

In School Dental Program Re-enrollment Form



Smiles on the Move

IN SCHOOL DENTAL PROGRAM



47 Town Street
Norwich, CT 06360
attn: *Smiles on the Move* (860) 822-4943

PLEASE FILL OUT IN INK

Student Information 	LAST NAME		FIRST NAME			MI
	STREET ADDRESS			CITY	ST	ZIP
	SCHOOL		TEACHER		GRADE	
	DATE OF BIRTH	SOCIAL SECURITY #	HOME PHONE	CELL PHONE		
	NAME OF RESPONSIBLE PARTY		RELATIONSHIP	WORK PHONE		

Dental Billing Information 	PRIMARY DENTAL INSURANCE			INSURANCE/MEDICAID ID#	
	INSURANCE COMPANY PHONE	GROUP #	POLICY HOLDER'S SSN	POLICY HOLDER'S DATE OF BIRTH	
	NAME OF POLICY HOLDER		POLICY HOLDER'S EMPLOYER		

Has the student ever been treated for or is currently being treated for:

CONDITION	Y	N	CONDITION	Y	N
Heart Murmur			Joint Replacement		

Is there anything else that you think the dental hygienist should know before treating the student? (fear of dentist, etc.) If yes, explain:

Student Medication Information

	Y	N
Does the student have any allergies to medications? If yes, please list:		
Please list any medications the student is currently taking:		

X	PARENT/GUARDIAN SIGNATURE		DATE	
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OFFICE USE ONLY	
PROVIDER SIGNATURE	DATE