Kids don't have to miss school. You don't have to miss work.

Your school has partnered with **Dental Access Carolina** to provide students with comprehensive dental care during school hours.

Here's how it works:

1. Sign the parental consent and medical history forms for your child. Return to the school nurse. You can also fill these out at **www.dentalaccesscarolina.com**
2. We will schedule your child for dental appointments during the school year in our state-of-the-art mobile clinics
3. Your child receives the highest quality dental care available, and you cross one more thing off your to-do list

- We accept **all forms of insurance.** Co-pays and deductibles may apply for private insurance
- To meet our staff, learn more about the program, or get answers to your questions, visit our website or call us at the number below

454 S. Anderson Rd, BTC 527
Suite 23
Rock Hill, SC 29730
(803) 324-3101
www.dentalaccesscarolina.com

Dental ACCESS Carolina

About Dental Access Carolina

History

Dental Access Carolina was founded in 2001 by Dr. John Reese, who sold his brick-and-mortar dental practice to focus on serving the oral health needs of South Carolina students in the mobile environment.

19 years later, we now operate six mobile clinics which deliver convenient, high-quality dental care to students in over 200 schools throughout the state.

What we do

We visit our partner schools on a recurring schedule with a full clinical team comprised of a licensed dentist, hygienist and dental assistant. Our mobile clinics are equipped with everything necessary to provide complete general dental services on-site, including:

- **Dental exams**
- **X-rays**
- **Cleanings**
- **Fillings**

During the school year, our dentist will evaluate each student and provide any necessary care. We always keep parents informed by notifying them of the exact treatment that their child receives.

If you have any questions about our program, please call us at (803) 324-3101. We look forward to hearing from you!

454 S. Anderson Rd, BTC 527
Suite 23
Rock Hill, SC 29730
(803) 324-3101
www.dentalaccesscarolina.com

Dental ACCESS Carolina

Dental Treatment Consent Form

Dear Parent/Guardian:

Dental Access Carolina offers complete general dental services on-site at your child's school. Our mobile clinics are equipped with everything necessary to provide preventive and restorative dental treatment. **If your child is enrolled in SC Medicaid, there is no cost to you!** We also accept private insurance from all major insurance carriers.

A team of professionals, **led by an experienced doctor**, will visit the school on a regular basis throughout the school year to provide dental services, including exams, x-rays, cleanings, fillings and more. You will receive a detailed report of any treatment your child receives after each visit.

☐ **Yes** – I want my child to receive dental care from Dental Access Carolina

- I am the legal guardian of my child
- I understand and consent to the information on this form

Sign this form, fill out front and back, and return to your child's teacher or school nurse

☐ **No** – I do not want my child to receive dental care from Dental Access Carolina

Child's Full Name:_____

Write your child's name above, then return this form to your child's teacher or school nurse

Signature of Parent/Guardian_____ Date _____

Printed Name of Person Completing Form_____

If you checked "YES", please fill out the blue box below AND the medical history on the back. SIGN the form and return to school!

Child's Full Name _____ Birthdate (mm/dd/yy) _____/_____/_____

School_____ Grade_____ Teacher _____

SC Medicaid # _____ (Include **ALL 10 Digits**)

OR

Insurance Company_____ Ins Co Phone _____

Subscriber name _____ Subscriber ID _____

Subscriber Social Security # _____ Subscriber Birthdate (mm/dd/yy) _____ / _____ / _____

Employer_____

Group Name _____ Group # _____

Patient's Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child

Parent or Guardian Name _____ Phone _____

Home Address _____ City _____ Zip _____

Email Address _____ Consent to Contact via Email? □ Yes □ No

Emergency Contact _____ Phone _____

PLEASE COMPLETE PATIENT'S MEDICAL HISTORY ON THE BACK OF THIS PAGE.

I understand and authorize Dental Access Carolina, LLC ("Provider") to provide dental care and treatment for the child listed above, and I certify that I am authorized to give such consent. I understand that the dental treatments which may be provided could generally include dental exams, x-rays, cleanings, dental sealants, fluoride treatment, fillings, extractions, pulpotomies and root canal treatments. I understand and have been advised that, as with any dental treatment, these procedures may entail some risk of complications, and that a list of such potential complications can be found at www.dentalaccesscarolina.com/FAQ. I authorize & direct Provider to bill & collect payment from Medicaid, insurance, or any other payer. I hereby authorize release of any information that will assist in treatment or in processing of claims for services rendered. If I have private dental insurance, I understand that I am responsible for any balance deemed patient responsibility/non-payable/non-covered by insurance. I understand that photographs may be taken for educational or documentation purposes and give consent. I have provided an updated medical history form to Provider (see reverse page). Provider is authorized to rely on said medical history form until notified of any change in writing. This signed consent authorizes treatment for my child at my child's initial and future dental visits. I may withdraw this consent at any time prior to treatment in writing.

Dental Access Carolina, LLC and its employees and affiliates are not agents or employees of the school district.
Rock Hill Office: 454 S. Anderson Road, Suite 23, Rock Hill, SC 29730 · Phone/Fax 803 324-3101
Charleston Office: 3300 W. Montague Ave., Suite 100, Charleston, SC 29418 · Phone 843 225-9506 · Fax 843 225-9507
www.dentalaccesscarolina.com

DENTAL ACCESS CAROLINA—PATIENT'S MEDICAL INFORMATION

Name _____ _____ _____ Birthdate (mm/dd/yy) _____/_____/_____

Sex _____ Height _____ Weight _____ Race (Circle One) White Black Hispanic Other _____

Name of Physician _____ Phone _____ Last Seen _____

Date of Last Dental Visit _____ Name of Dentist _____ City _____

PATIENT'S MEDICAL INFORMATION

Yes No

_____ _____ Have you been seriously ill in the last 5 years? If yes, explain: _____

_____ _____ Have you ever been hospitalized or had a serious illness? If yes, explain: _____

_____ _____ Has a doctor told you to take antibiotics before ALL dental treatments?

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

Yes	No		Yes	No	
_____	_____	Antibiotics (Penicillin, etc.)	_____	_____	Insulin (Diabetes Medication)
_____	_____	Anticoagulants (blood thinners)	_____	_____	High Blood Pressure Medications
_____	_____	Antihistamine (Benadryl, etc.)	_____	_____	Nitroglycerine
_____	_____	Aspirin (Advil, Nuprin, etc.)	_____	_____	Sulfa Drugs
_____	_____	Cortisone (Steroids)	_____	_____	Tranquilizers
_____	_____	Digitalis (Heart Medicine)	_____	_____	Other, Please list _____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO?

Yes	No		Yes	No		Yes	No	
_____	_____	Antibiotics (Penicillin, etc.)	_____	_____	Local Anesthetics	_____	_____	Latex
_____	_____	Barbituates (Sleeping pills)	_____	_____	Narcotics (Codeine, etc.)	_____	_____	Red Dye
_____	_____	Sulfa Drugs	_____	_____	Other, Please list _____			

DO YOU HAVE OR HAVE YOU HAD?

Yes	No		Yes	No		Yes (Si)	No	
_____	_____	AIDS/HIV Positive	_____	_____	Asthma/Hay Fever	_____	_____	Drug Interactions
_____	_____	Chemotherapy	_____	_____	Allergies	_____	_____	Epilepsy Seizures
_____	_____	Bleeding Problems	_____	_____	Cortisone/Steroids	_____	_____	Frequent Fainting
_____	_____	Anemia	_____	_____	Cancer or Tumor	_____	_____	Shortness of Breath
_____	_____	Sugar Diabetes	_____	_____	Drug Addiction	_____	_____	Head Injury
_____	_____	Heart Trouble or Murmur	_____	_____	Hepatitis-Jaundice	_____	_____	Kidney Disease
_____	_____	Hives	_____	_____	Prosthetic Hip/Heart Valve	_____	_____	Psychological Problems
_____	_____	Frequent Headaches	_____	_____	Liver Disease	_____	_____	Sinus Trouble
_____	_____	Stroke	_____	_____	Rheumatic Fever/Rheumatic Heart Disease			
_____	_____	Thyroid Disease	_____	_____	Radiation for Head/Neck Cancer			
_____	_____	Venereal Disease	_____	_____	Tuberculosis/Lung Disease			

Do you have any other medical condition(s) that we should know about? If so, please explain: _____

_____

_____

_____