HEALTHY SMILE
HEALTHY CHILD

If you have Medicaid/NV Check Up please bring your card. Healthy Smile Healthy Child requires the following if you don't have Medicaid/NV Check-Up or your child is uninsured: proof of income *(2 months)*, proof of address, and proof of household *(ID's, or birth certificate,).* An administrative application fee of $300.00 will apply once you have qualified for the program.

Referring Agency _____ Phone# _____ Name of Dentist _____ Dentist Signature _____

REASON FOR REFERRAL: **GENERAL ENDODONTIST ORALSURGEON PEDIATRIC PERIODONTIST ORTHO**

TRIAGE 1 2 3 4 5 (*1 high risk 5 low risk*) **Emergecy** Yes No **X-Ray:** Yes No **TX PLAN:** Yes No **RETREATMENT:** Yes No (*PLEASE CHECK AND SEND WITH REFERRAL*)

TEETH TO BE EVALUATED/TREATED: _____ **Medicaid/NV Check Up #** _____

PATIENT INFORMATION

LAST NAME _____ **FIRST NAME** _____ **MI** _____

SEX ☐ **M** ☐ **F** **DOB** _____ **AGE** _____ **SOCIAL SECURITY#** _____

PLACE OF BIRTH _____ **RACE** _____ **PHONE#** _____

ADDRESS _____ **APT/SPACE #** _____

CITY _____ **STATE** _____ **ZIP CODE** _____

NAME OF PEDIATRICIAN/MEDICAL CLINIC _____ **PH#** _____

1# EMERGENCY NAME _____ **PH#** _____ **RELATIONSHIP** _____

2# EMERGENCY NAME _____ **PH#** _____ **RELATIONSHIP** _____

MOTHER/GUARDIAN

Name _____ Name of Employer _____

☐ SAME AS ABOVE Address _____ Street _____ Apt# _____ City _____ State _____ Zip _____

Cell Phone# _____ Home Phone# _____ E-Mail _____ Work Phone# _____

FATHER/GUARDIAN

Name _____ Name of Employer _____

☐ SAME AS ABOVE Address _____ Street _____ Apt# _____ City _____ State _____ Zip _____

Cell Phone# _____ Home Phone# _____ E-Mail _____ Work Phone# _____

I / We certify that all statements in this application are true and complete. I authorize Healthy Smile Healthy Child to obtain such information as may be required concerning statements made in this application. If you are a legal guardian, documentation must be submitted. I understand I must be uninsured and meet the programs income guidelines to qualify, and this application must be updated annually.

Signature of Parent/Guardian _____ Relation to Patient _____ Date _____
Relación al Paciente Fecha

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