Please call to make an appointment or for more information at 775.982.7989 or via email mvazquez@renown.org

If you have Medicaid/NV Check Up please bring your card. Healthy Smile Healthy Child requires the following if your child is uninsured: proof of income *(2 months-consecutive)*, proof of address (utility or phone bill), and proof of household composition *(ID or birth certificate-for each member).* 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** **ORAL SURGEON** **PEDIATRIC** **PERIODONTIST** **ORTHO**

TEETH TO BE EVALUATED/TREATED: ______

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

Last Dental Visit ______ **Medicaid/NV Check Up #** ______ ☐ Liberty ☐ HP Enterprise

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 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