Are your children in need of dental care that you cannot afford AND are you uninsured for dental care?

Your child(ren) may be eligible to participate in one day of free dental care. Some area dentists will participate in the Ohio Dental Association's annual Give Kids a Smile program on DATE _____ … and give **free dental care** (exams, cleanings, fluoride and sealants; some sites will also do fillings and extractions) to children in need and who have no other resources to get that care. The number of available appointments is limited – so respond by the date shown below!

Children must be pre-registered and referred to this program and have means of transportation to the dental office. The parent or legal guardian must sign and return the health history and consent form that will be provided before their child(ren) can go to the dental site for the free services.

Children seen through the Give Kids a Smile program should meet any or all of the following circumstances:

their families have no private dental insurance, the children have not seen a dentist and the family cannot afford dental care,
families are living on a limited income,
families are experiencing financial difficulty (could be due to divorce, illness, death, loss of job, etc.),
the child/family is not a current patient at another dental office

Some dentists prefer children who not have Medicaid eligibility as they do have access to dental care; however, if the family has not taken their child to a dentist, the child may still be seen.

To have your child considered* for this program, please fill out and return the form on the back of this flier by _____ (date). For additional information, call:

Contact name/number

***First consideration will be given to children whose families respond by the date shown above and to children most in need. For responses after the due date, children may be scheduled if appointment spots are still open.**

FAMILY INFORMATION

Please print clearly:

Child's name: _____ Date of Birth:_____

School:_____ Grade:_____

Parent/Guardian's name(s): _____

Address/City/Zip Code: _____

Home phone #:_____ Work phone #:_____

Cell phone #:_____

Does your child have Medicaid coverage or eligibility for Medicaid? _____Yes _____ No
If yes, who is your Managed Care Plan with? _____

Do you have dental insurance? _____ Yes _____ No

If yes, who is the insurance company?_____

Is your child complaining of tooth or mouth pain? _____ Yes _____ No

Do you have a family dentist and what is his/her name? _____

When was your child's last visit to the dentist? _____

Dentist name/city & state: _____

Are there other children in the home that are in need of a dental examination and/or care?

Please list: Name	Grade, Age & School Attended
_____	_____
_____	_____
_____	_____
_____	_____

Parent/guardian signature: _____

Please return this form no later than _____, _____ to:

_____

Contact name/number