Child's Name: _____

SMILE MOBILE

1516 Bridge School Rd
Rolla, MO 65401
573.458.8645~ 573.426.2263 (fax)

Parent(s)/Guardian(s),

Your school district has partnered with Your Community Health Center (YCHC) to bring you our mobile dental unit the Smile Mobile again this year! This program will provide any pre-registered child an opportunity to receive dental services at school during normal school hours. If your child already sees a local dentist, however, we strongly recommend that he/she remain with that practice.

We offer comprehensive dental care. Our services include: examinations, cleanings, X-Rays, fillings, extractions, and some crowns. There may be some procedures that cannot be completed on the mobile unit and it may be necessary to refer those patients to another dentist. We will provide referral information if this is necessary.

YCHC's Smile Mobile is able to serve all children in your district, who complete registration information and make advance financial arrangements. If your child is on any of the Missouri Medicaid programs, he/she will still be seen at no additional cost to you. In addition, we accept dental insurance or self-pay patients. If your child is uninsured, YCHC staff can work with the parent/guardian to get them approved for Missouri Medicaid. We also offer a sliding scale discount program for those who qualify. Information and application forms for our sliding scale discount program are attached to this package.*

The Smile Mobile is scheduled to be at:_____
during the weeks of:_____.

Parents, please complete the registration packet IN INK and return it to school by:_____
in order for your child to be seen. We look forward to working with you and your child!

*If you have any questions about our services, please contact us at smilemobile@your-chc.org or call 573-458-8645 or for help with Medicaid enrollment email ktroutt@your-chc.org or call 573-458-3869.

Dental History

Has your child ever been to a dentist? ☐ Yes ☐ No

Does your child have a local dentist? ☐ Yes ☐ No If yes, Dentist's Name and City _____

Has child been seen in the last 12 months? ☐ Yes ☐ No If yes, when _____

What services were performed? _____

List any current dental problems/complaints your child has. _____