



Good news, we had enough parents turn in consent forms back in Nov to have Miles of Smiles schedule a visit to Rockdale school. Miles of Smiles will be coming to Rockdale School Thursday March 16th 2023. For those that have already sent in completed consent forms, your child will be seen by the dentist during the school day on Thursday March 16th. If a completed consent form was not turned in and you would like your child seen by the dentist at school on March 16th it's not too late. A consent form can be picked up in the health office during the school day or it can be found on the school website under Health services. There are still openings for more students to be seen, so turn in your consent form today.

Please keep in mind dental exams are state mandated for children in kindergarten, 2nd and, 6th grade. For current kindergarten, 2nd or 6th grade students that have not satisfied their dental exam requirement, this would satisfy that state mandate.

Also for current 1st and 5th graders, next year's dental exam requirement would be fulfilled with the dental exam Miles of Smiles will provide. Why not get a head start on next year's requirements?



Miles of Smiles, Ltd.

ATTENTION PARENTS!!!!!!

IT IS MORE IMPORTANT THAN EVER TO SIGN YOUR CHILD UP FOR MILES OF SMILES, LTD!

COVID-19 has been a barrier to getting children the dental care they need.

Miles of Smiles, Ltd. has resumed the school-based dental program and assures you that infection control will continue to be our top priority.

The "CDC supports states to put into action **school sealant programs** that reduce oral disease and improve oral health." *CDC.gov/oral health/dental sealant programs*

- Miles of Smiles, Ltd. is providing preventive dental services at your school to eligible children in **all grades**.
- Services may include exam, cleaning, fluoride varnish, and sealants if needed.
- This also satisfies the dental requirement mandated by the State of Illinois for school children: (Kindergarten, 2nd, 6th, and 9th).
- Please sign up your child today to receive this wonderful service.
- There is **no cost** to the family or school.
- After the services are performed, the following entities will be billed where applicable: IL Medicaid program, public/private grants, or private dental insurance.
- Miles of Smiles, Ltd. will accept any reimbursement as the final payment (even if the claim is denied). The families and the schools are never billed for any copayments, deductibles, or balances.

There is never any cost to the school or to the families.

***If you see a dentist regularly,
please continue for routine exams and x-rays!***

All Kids online application & forms:
<https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/application.aspx>
All Kids Hotline: 1-866-ALL-KIDS (1-866-255-5437)

2424 N 8th St. * Pekin, IL 61554-1547 * Office: 309-382-6404 * Fax: 309-382-6405

ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

Rev.06/17

PLEASE PRINT IN INK

DENTAL EXAM

★ **MUST BE RETURNED TOMORROW** (ONLY IF YOU WANT THESE SERVICES) ★



Services Rendered By:
309-382-6404
Miles of Smiles, Ltd.
2424 N 8th St.
Pekin, IL 61554-1547

NAME OF SCHOOL: _____
TEACHER: _____
COUNTY: _____ GRADE: _____

DO YOU HAVE A DENTIST? YES / NO DENTIST'S NAME: _____ EXAM DATE: _____

PROVIDE THE FOLLOWING INFORMATION ONLY IF YOU WANT THESE DENTAL SERVICES



to be rendered by Miles of Smiles, Ltd at school.

Dear Parent or Guardian,
Miles of Smiles, Ltd. and The Illinois Department of Healthcare and Family Services have arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists, and assistants will come to your child's school with portable equipment. In order for your child **to receive these services**, you must **PROVIDE ALL THE INFORMATION REQUESTED BELOW AND SIGN** IN THE AREA INDICATED.

YOUR CHILD'S LEGAL NAME: _____ BIRTH DATE: ____/____/____
ADDRESS: _____ GENDER: M / F
CITY/ZIP: _____ HOME PHONE: _____

DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS: YES / NO
IS YOUR CHILD ENROLLED IN THE 'Medicaid/All Kids' PROGRAM: YES / NO
MCO COMPANY NAME (if not listed): _____

MCO COMPANY NAME (circle one): Aetna, BCBS, Cigna, CommunityCare, CountyCare, Family Health Network, Harmony, Humana, IlliniCare, Meridian, Molina

IF YES, INCLUDE YOUR CHILD'S RECIPIENT ID NUMBER: _____ →
Medicaid/All Kids will be billed (9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD)

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES / NO (if incomplete, only grades K, 2nd, & 6th may be eligible for an exam)

Name of Dental Insurance Company: _____
Dental Insurance Company Address: _____
Member's (employee) ID or SS #: _____ Dental Insurance plan or group number: _____
Member's name: _____ Member's Birth Date: _____
Member's Address (if different than child's): _____
Member's Phone Number (if different than child's): _____ Employer: _____

Has your child had any history of, or conditions related to, any of the following: (Please circle)							
Anemia:	YES / NO	Chronic Sinusitis:	YES / NO	Growth problems:	YES / NO	Seizures:	YES / NO
Asthma:	YES / NO	Diabetes:	YES / NO	Hearing:	YES / NO	Thyroid:	YES / NO
Bleeding disorders:	YES / NO	Ear aches:	YES / NO	Heart Disease:	YES / NO	Tobacco / drug use:	YES / NO
Cancer:	YES / NO	Epilepsy:	YES / NO	Latex allergy**:	YES / NO	Allergies:	
Cerebral Palsy:	YES / NO	Fainting:	YES / NO	Pregnancy (teens):	YES / NO	Other:	
Is your child taking any prescription and/or over the counter medications at this time?					YES / NO		
If yes, please list: _____							
Does your child have any known heart condition? YES / NO DESCRIBE: _____							
Does your child have any artificial joints: YES / NO IF YES, WHEN & WHAT JOINT: _____							
Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? YES / NO							
IF YES, WHAT: _____							

IMPORTANT: PARENT/GUARDIAN SIGNATURE REQUIRED (ONLY IF YOU WANT THESE SERVICES)

I am a custodial parent or legal guardian of the minor child named above. I **authorize and consent** to this child receiving the dental treatment described, and allow the school nurse/ school representative and dental provider access to child's dental record.

This will also give permission for the Illinois Department of Public Health to provide Quality Assurance Audits by evaluation of your child's sealants that were placed at the school. Upon determination, this permission will also allow for the sealants to be replaced by the provider if indicated.

To the extent permitted by law, I consent to the use and disclosure of the minor child's protected health information to carry out payment activities in connection with this claim. I hereby **authorize and direct payment** of the dental benefits directly to Miles of Smiles, Ltd.

SIGNATURE: _____ DATE: _____

IF YOU HAVE A DENTIST, SEEK DENTAL CARE THERE! DDS INITIALS _____ RDH INITIALS _____