# DENTAL CONSENT FORM

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Dental Safari Company
7562 Old Rt 13
Marion, IL 62959
(618) 993-8333
(618) 993-8335 fax
contact@DentalSafariCompany.com

**School** _____ **Grade** _____

**County** _____ **Teacher** _____

**Now! Can Fill Out / Submit Online!!**

**Parents/Guardian:** DENTAL SAFARI COMPANY, a fully licensed, professional corporation, will be at your child's school.
By signing this consent form, your child receives an exam (no x-rays) by a licensed dentist, cleaning, Fluoride, and sealants as needed.

**Child's Name** _____ ☐ Male ☐ Female Birth Date ____ / ____ / _____

Address _____City_____ZIP_____Phone_____

**Parent/Guardian Cell Phone**: _____ **OK, to text?** ☐ Yes ☐ No **e-mail**: _____

**Please select the METHOD OF PAYMENT you would like to use (check one):**

- ☐ Medicaid / All Kids (9-digit ID# required)
- ☐ Private Insurance – Most private insurance pays 100% on services we perform (questions: call (618) 993-8333)
- ☐ Self-Pay - Credit Card / PayPal (go to website) **www.DentalSafariCompany.com**
  - ☐ **Full Price** $128 [due with consent form]
  - ☐ **Reduced Fee** ($75 total. [due with consent form] ***Must Sign Declaration below)***

* If you prefer Cash / Check
Please call our office to arrange.
(618) 993-8333

*Cash Payment Declaration/Reduced Fee Waiver*
For financial reasons, Parent/Guardian is unable to pay Full Price for dental services at this time.

_____
*(print name)* *signature* *date*

- ☐ Grant Fund – Child is **ON** FREE OR REDUCED LUNCH PROGRAM but has **NO** MEDICAL CARD #.

Is Child Eligible for Free or Reduced Lunch? ☐ YES ☐ NO
**Medical Card KidCare / All Kids Card RECIPIENT ID#** ___ ___ ___ ___ ___ ___ ___ ___ ___ (*9-digit # on back of Card*)

Does Your Child have PRIVATE Dental Insurance? ☐ YES ☐ NO Employer _____
Primary Card Holder Name _____Phone_____
Primary's Address _____
Primary's: Birth Date ____ / ____ / _____; Primary's Soc. Sec. #: _____ - _____ -_ _____
DENTAL insurance company _____ Insurance Company Phone _____
Member ID#:_____; Group #: _____

## HEALTH HISTORY – PLEASE FILL OUT COMPLETELY

Has your child had any history of the following? Check ALL that apply:

| | | | | |
|---|---|---|---|---|
| ☐ AD/HD | ☐ Blood Disorders | ☐ Diabetes | ☐ Heart | ☐ Speech Difficulties |
| ☐ Allergies (seasonal) | ☐ Cancer | ☐ Ear Aches | ☐ Heart Murmur | ☐ Surgeries |
| ☐ Asthma | ☐ Cerebral Palsy | ☐ Growth Problems | ☐ Pregnancy | ☐ Tobacco/Drug Use |
| ☐ Autism | ☐ Chronic Sinusitis | ☐ Hearing | ☐ Seizures | ☐ Other |

Other (checked above) Please Describe: _____

☐ YES ☐ NO Have you been told your child requires antibiotics before dental procedures due to a medical condition?
☐ **YES** ☐ **NO** **Is child allergic to ANY medication?** list _____
☐ YES ☐ NO Is child taking ANY medications at this time?
_____
☐ YES ☐ NO Has your child ever suffered injuries to the mouth, head, or teeth?
_____
☐ YES ☐ NO Does child's home have well water?

**IMPORTANT: PARENT / GUARDIAN SIGNATURE REQUIRED**
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 representative and dental provider access to child's dental record. *By signing, you give permission to treat your child and understand your HIPPA rights – which can be reviewed at www.DentalSafariCompany.com. Also, this gives permission for HFS, QA Audits and providers to return to your school and re-check your child's sealants.*

_____
**PRINT NAME** relation **SIGNATURE** date

**Optional: Photo/Video Release For Minor Child**

_____parent/guardian
_____child
I, as parent/guardian, of the above child, give permission to Dental Safari Company to take and use pictures/videos in promotional material with no compensation to me. NOTE: Your child's name will not be used unless further permission is given.

_____
*(signature)*

**Interested in a 6-Month Recall Appointment?**
This includes dental screening, cleaning, Fluoride and sealants by a Registered Dental Hygienist.

☐ **YES** ☐ **NO** ☐ **I need more information**

**IMPORTANT: Parent / Guardian Consent**
I am a custodial or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment at this 6-month recall appointment.

_____
*signature* *date*




Dentist's Initials _____