

DENTAL CONSENT FORM



we're on facebook

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) Full Price \$128 [due with consent form]
- www.DentalSafariCompany.com 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 (9-digit # on back of Card)
Medical Card KidCare / All Kids Card RECIPIENT ID# _____

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 #: _____

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)

HEALTH HISTORY – PLEASE FILL OUT COMPLETELY

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

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

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

PRINT NAME relation SIGNATURE date