

DENTAL CONSENT FORM



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, child receives an exam by a licensed dentist, cleaning, Fluoride, sealants and SDF caries treatment

Is Child at school? 100% e-learning (at home) Blended (check days at school) Mon Tues Wed Thur Fri
 Is Child returning patient Yes No
 Do you want Child to have appropriate dental x-rays? Yes No

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 #.**

_____ (9-digit # on back of Card)

Is Child Eligible for Free or Reduced Lunch? YES NO
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:

<input type="checkbox"/> AD/HD	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Speech Difficulties
<input type="checkbox"/> Allergies (seasonal)	<input type="checkbox"/> Cancer	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Surgeries
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Tobacco Drug Use
<input type="checkbox"/> Autism	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Seizures	<input type="checkbox"/> 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? _____

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

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 _____

Dentist's Initials _____