

# ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

Rev.06/17

PLEASE PRINT IN INK

## DENTAL EXAM

Services Rendered By:

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



NAME OF SCHOOL: \_\_\_\_\_  
 TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_  
 COUNTY: \_\_\_\_\_

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

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      MCO COMPANY NAME (circle one): Aetna, BCBS, Cigna, CountyCare, CommunityCare, Harmony, Humana, Illini Care, Meridian, Family Health Network, Molina  
 IS YOUR CHILD ENROLLED IN THE 'Medicaid/All Kids' PROGRAM: YES / NO  
 MCO COMPANY NAME (if not listed): \_\_\_\_\_

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)

If YES, please fill out ALL the insurance information below: **(DENTAL INSURANCE COMPANY WILL BE BILLED)**

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
Asthma:	YES / NO	Diabetes:	YES / NO	Hearing:	YES / NO
Bleeding disorders:	YES / NO	Ear aches:	YES / NO	Heart Disease:	YES / NO
Cancer:	YES / NO	Epilepsy:	YES / NO	Latex allergy**:	YES / NO
Cerebral Palsy:	YES / NO	Fainting:	YES / NO	Pregnancy (teens):	YES / NO
				Tobacco / drug use:	YES / NO
				Allergies:	
				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.

I also consent to be contacted by the **Central Counties Health Centers, Inc.** to schedule a follow up appointment if needed.

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: \_\_\_\_\_ PRINT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**IF YOU HAVE A DENTIST, SEEK DENTAL CARE THERE!**      DDS INITIALS \_\_\_\_\_ RDH INITIALS \_\_\_\_\_

**\*\*DO NOT WRITE BELOW THIS LINE\*\***

## ALL KIDS SCHOOL-BASED DENTAL PROGRAM DENTAL RECORD

(BELOW TO BE COMPLETED BY MILES OF SMILES, LTD. DENTIST)

### PRIOR TREATMENT

Restorations:	Sealants:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### TREATMENT NEEDED

Restorative:	Sealants: ✓	Sealants: ✓
_____	S _____	S _____
_____	S _____	S _____
_____	S _____	S _____
_____	S _____	S _____
_____	S _____	S _____
_____	S _____	S _____
_____	S _____	S _____

(Check off sealants placed today; occlusal is assumed)

ORAL HYGIENE STATUS:	_____ Good	_____ Fair	_____ Poor
PERIODONTAL STATUS:	_____ Good	_____ Fair	_____ Poor
MALOCCLUSION:	I	II	III

(Circle one) **ORAL HEALTH ASSESSMENT RATING & SCORE:**



3	<u>URGENT</u> Treatment:	5+ carious lesions, gross caries, root tips, caries likely to involve pulpal tx, abscess, soft tissue pathology, pain from disease or foreign object.
2	<u>RESTORATIVE</u> Care:	4 or less cavitated, occlusal, or incipient caries. Caries not close proximity to pulpal tissue.
1	<u>PREVENTIVE</u> Care: (services rendered today)	There is no visual evidence of caries activity or periodontal pathology.

**TREATMENT COMPLETED TODAY (check off)**

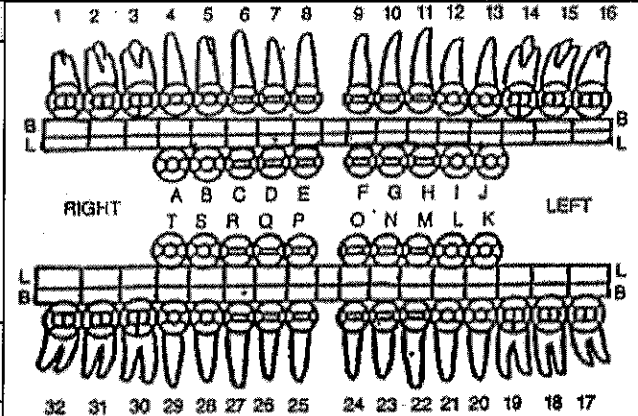
EXAM  
 PROPHYLAXIS  
 FLUORIDE TREATMENT VARNISH / GEL  
 SEALANTS (tooth #'s listed above)

Total # sealants placed today: \_\_\_\_\_

Treatment Date: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_

Hygienist's Initials: \_\_\_\_\_



Charting: BLUE=existing restorations; RED=treatment needed

<input type="checkbox"/> NO TX	<input type="checkbox"/> MOS yellow	<input type="checkbox"/> CCHC green	OTHER DR: <input type="checkbox"/> Haarman purple	<input type="checkbox"/> Dietz blue	<input type="checkbox"/> REFER red
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NOTES: