

ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

PLEASE PRINT IN INK

DENTAL EXAM

Services Rendered By:

MUST BE RETURNED TOMORROW

(up to a \$475 value)

NAME OF SCHOOL: _____

TEACHER: _____ GRADE: _____

COUNTY: _____



Miles of Smiles, Ltd.

137-F Radio City Dr.

North Pekin, IL 61554

309-382-6404

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 CHILDS 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

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 *(The dental insurance company will be billed)*

If YES, please fill out **ALL** the insurance information below: (if incomplete, only grades K, 2nd, & 6th may be eligible for an exam)

Name of Dental Insurance Company: _____

Dental Insurance Company Address: _____

Dental Insurance Company plan or group number: _____

Name of the Insured: _____ Phone # of the Insured: _____

Address of the Insured: _____

Insured Date of Birth: _____ Insured ID or SS #: _____

Employer: _____ Employer Phone #: _____

Employer Address: _____

| 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: | 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: | | | | | | | |

What type of water does your child drink? ___City water ___Well water ___Bottled water ___Filtered 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/ school representative and dental provider access to child's dental record.

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: _____