ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

Rev.06/17

PLEASE PRINT IN INK

DENTAL EXAM

Services Rendered By:

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

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

NAME OF SCHOOL:_____

TEACHER:_____ GRADE: _____

COUNTY:_____

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

IS YOUR CHILD ENROLLED IN THE 'Medicaid/All Kids' PROGRAM: YES / NO

MCO COMPANY NAME (if not listed): _____

MCO COMPANY NAME (circle one): Aetna, BCBS, Cigna, CountyCare, CommunityCare, Harmony, Humana, Illini Care, Meridian, Family Health Network, Molina

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	Seizures:	YES / NO
Asthma:	YES / NO	Diabetes:	YES / NO	Hearing:	YES / NO	Thyroid:	YES / NO
Bleeding disorders:	YES / NO	Ear aches:	YES / NO	Heart Disease:	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:

Does you 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_____