

# ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

2021

PLEASE PRINT IN INK

## DENTAL EXAM

Services Rendered By:

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



Miles of Smiles, Ltd.

2424 N 8th St

NAME OF SCHOOL: \_\_\_\_\_

TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_

Pekin, IL 61554-1547

COUNTY: \_\_\_\_\_

309-382-6404

DO YOU HAVE A DENTIST? YES / NO      DENTIST'S NAME: \_\_\_\_\_      EXAM DATE: \_\_\_\_\_

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**PROVIDE THE FOLLOWING INFORMATION ONLY IF YOU WANT THESE DENTAL SERVICES**  
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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, CountyCare, Meridian, Molina, YouthCare.
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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 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.

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 \_\_\_\_\_