DENTAL CONSENT FORM

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Dental Safari Company
7562 Old Rt 13
Marion, IL 62959
(618) 993-8333
contact@DentalSafariCompany.com

School _____ **Grade** _____

County _____ **Teacher** _____

☐(O.S.)R. ☐(P.R.) ☐1st ☐2nd

Parents/Guardian

DENTAL SAFARI COMPANY, a fully licensed, professional corporation, will be at your child's school. By signing this consent form, your child will receive a visual exam (no x-rays) by a licensed dentist, a cleaning, Fluoride, and sealants as needed.

ALL CHILDREN ARE ELIGIBLE. Please select the method of payment you would like to use (check one):

- ☐ Medicaid / All Kids (9-digit ID# required)
- ☐ Grant Fund – Child is on the free or reduced lunch program but has NO MEDICAL CARD #.
- ☐ Private Insurance – Most private insurance pays 100% on services we perform (questions: call (618) 993-8333)
- ☐ Cash (or Check) Payment (pick one) ☐ **Full Price** $128[due with consent form]
  ☐ **Reduced Fee** ($68 total. [due with consent form] ***Must Sign Declaration below)***

Checks make payable to:
Dental Safari Company
(Include Driver License # on check)

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*

Child's (legal) Name _____ ☐ Male ☐ Female Birth Date ____ / ____ / _____
Address_____City_____Zipcode_____
Phone_____ Cell Phone _____ e-mail _____

Is Child Eligible for Free or Reduced Lunch? ☐ YES ☐ NO (*9-digit # on back of Card*)
Medical Card KidCare / All Kids Card RECIPIENT ID# ___ ___ ___ ___ ___ ___ ___ ___ ___

Does Your Child have PRIVATE Dental Insurance? ☐ YES ☐ NO
Primary Card Holder Name _____Phone_____ Employer _____
Primary's Address _____
Primary's: Birth Date ____ / ____ / _____; Primary's Soc. Sec. #: _____ - _____ -_ _____
DENTAL insurance company _____ Insurance Company Phone _____
Member ID#:_____; Group #: _____

☐ **YES** ☐ **NO** **NEED FOR PREMEDICATION?** – Does your child need to be premedicated before dental treatment?
**** IF YES** – Please call our office: (618) 993-8333

HEALTH HISTORY – IMPORTANT. MUST BE FILLED OUT COMPLETELY

Has your child had any history of, or conditions related to, ANY of the following? Check ALL that apply:

☐ AD/HD	☐ Allergies (seasonal)	☐ Anemia	☐ Asthma	☐ Bleeding Disorders	☐ Blood Disorders
☐ Cancer	☐ Cerebral Palsy	☐ Chronic Sinusitis	☐ Diabetes	☐ Ear Aches	☐ Epilepsy
☐ Fainting	☐ Growth Problems	☐ Hearing	☐ Heart	☐ Heart Murmur	☐ Latex Allergy
☐ Pregnancy (teens)	☐ Seizures	☐ Thyroid	☐ Tobacco / Drug Use	☐ Other (list / describe below)	

Other (checked above) Please Describe: _____

☐ **YES** ☐ **NO** **Is child allergic to ANY medication?**
If Yes, please list _____
☐ YES ☐ NO Is child taking ANY over-the-counter OR prescription medications at this time?
If Yes, please list _____
☐ YES ☐ NO Does your child have any speech difficulties?
☐ YES ☐ NO Has your child ever suffered injuries to the mouth, head, or teeth?
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.

_____
SIGNATURE ***(RELATION TO CHILD)*** ***DATE***

* By signing, you give permission to treat your child and understand your HIPPA rights.
[HIPPA form can be reviewed at www.DentalSafariCompany.com, or a copy can be sent to you by using DENTAL SAFARI COMPANY'S contact information in upper-right corner of this Consent Form]
* Also, gives permission for HFS, QA Audits and providers to return to your school and re-check your child's sealants.

Optional: Photo 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 in promotional material with no compensation to me. NOTE: Your child's name will not be used unless further permission is given.

_____
(signature)

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Dentist's Initials _____