# ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

## DENTAL TREATMENT CONSENT AND REGISTRATION



*This form is to obtain your consent for dental treatment or oral surgery procedures.*

***If you have a dentist, schedule an appointment there.***

*PLEASE PRINT IN **INK***

MUST BE RETURNED TOMORROW

*Please read ALL forms very carefully and ask us about anything that you do not understand.*

**Miles of Smiles, Ltd.**
137-C Radio City Dr.
North Pekin, IL 61554
309-382-6404

NAME OF SCHOOL:_____

TEACHER:_____ GRADE: _____

COUNTY:_____

YOUR CHILD'S LEGAL NAME:_____ BIRTH DATE: _____/_____/_____

ADDRESS:_____ GENDER: M / F

CITY/ZIP:_____ HOME PHONE: _____-_____-_____

**DO YOU HAVE A DENTIST?** YES / NO DENTIST'S NAME:_____

DO YOU NEED ASSISTANCE IN SCHEDULING AN APPOINTMENT WITH YOUR DENTIST? YES / NO

DENTIST'S PHONE NUMBER:_____ DENTIST'S ADDRESS:_____

**ONLY PROVIDE THE FOLLOWING INFORMATION *IF YOU WANT 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. ***This form is to obtain your consent for dental treatment or oral surgery procedures.*** Licensed dentists, and their assistants will come to your child's school with portable equipment. In order for your child ***to receive these services*** YOU MUST **PROVIDE** ALL OF THE **INFORMATION** REQUESTED AND **SIGN** IN THE AREAS INDICATED.

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)

**IMPORTANT! PARENT/GUARDIAN SIGNATURE REQUIRED:**

(Only if you want these services to be rendered by Miles of Smiles, Ltd at school)

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 (on the following pages), 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:** _____

Services to be rendered by: Miles of Smiles, Ltd, Call 309-382-6404 if you have questions

## MEDICAL HEALTH HISTORY FORM

Patient's Legal Name_____ Date of Birth_____
Medical Doctor_____ Doctor's Phone #:_____
Date of Last Medical Visit_____ Reason for medical visit_____
1. Is patient currently under the care of a medical doctor? Yes / No Reason:_____
2. Is patient taking any prescription and/or over-the-counter medications? Yes / No
If yes, list drugs: a._____ Reason_____
b._____ Reason_____
c._____ Reason_____
3. Is patient allergic to penicillin? Yes / No
4. Is patient allergic to any other medications? Yes / No
If yes, please state name of drug(s) & reaction(s):_____
5. FEMALES: Is there any possibility patient is pregnant? Yes / No
If yes, how many months?_____ Taking birth control pills? Yes / No
6. Has patient received local anesthetic before (numbing medicine)? Yes / No
If yes, any adverse reactions? Yes / No If yes, what reaction?_____
7. Does patient have any artificial joints? Yes / No If yes, when & what joint?_____
8. Does patient have any known heart conditions? Yes / No
If yes, please describe:_____
9. Has patient's doctor recommended any special precautions or pre-medications for dental treatment? Yes / No
If yes, what?_____

| 10. Does patient have or ever had any of the following? | Yes | No | Comments |
|---|---|---|---|
| Alcohol and/or drug dependency | ___ | ___ | _____ |
| Anemia | ___ | ___ | _____ |
| Asthma, wheezing, or breathing problems | ___ | ___ | _____ |
| Birth defects, or genetic defects | ___ | ___ | _____ |
| Bleeding or blood clotting problems/diseases | ___ | ___ | _____ |
| Cancer, leukemia, other tumor | ___ | ___ | _____ |
| Cerebral Palsy | ___ | ___ | _____ |
| Chronic Sinusitis | ___ | ___ | _____ |
| Developmental disabilities | ___ | ___ | _____ |
| Diabetes (blood sugar problems) | ___ | ___ | _____ |
| Ear aches | ___ | ___ | _____ |
| Epilepsy, seizures or fainting spells | ___ | ___ | _____ |
| Growth problems | ___ | ___ | _____ |
| Heart disease, heart murmur, or heart surgery | ___ | ___ | _____ |
| Hepatitis or other liver problems | ___ | ___ | _____ |
| HIV and/or AIDS | ___ | ___ | _____ |
| Kidney problems | ___ | ___ | _____ |
| Latex allergy | ___ | ___ | _____ |
| Sickle cell anemia or trait | ___ | ___ | _____ |
| Steroid treatment or use | ___ | ___ | _____ |
| Thyroid problems | ___ | ___ | _____ |
| Tobacco use | ___ | ___ | _____ |
| Tuberculosis | ___ | ___ | _____ |

11.Does the patient have any known allergies not listed? Yes / No
If yes, what allergies?_____
11. Does patient have a history of, or is currently suffering from a medical condition not mentioned above? Yes/No
If yes, what is the medical condition(s)?_____
12. Indicate if patient has any of these: ___Blindness ___Hearing Problems ___Speech Problems

**IMPORTANT! PARENT/GUARDIAN SIGNATURE REQUIRED:**
**I certify that I have read and understood the above questions. To the best of my knowledge the above information is correct. I will not hold the treating dentist(s) or any member of the dental staff responsible for any errors or omissions I may have made in the completion of this form. I understand that it is my responsibility to inform my patient's dentist when there is a change in my patient's medical condition, or when there is a change in the responses to any of the above questions.**

**PRINT YOUR NAME:** _____ **RELATIONSHIP TO PATIENT:** _____
**Are you legally responsible for this patient?** _____

**SIGNATURE:**_____ **DATE:**_____ **TIME:**_____

## DENTAL TREATMENT CONSENT AND REGISTRATION



1. Below is **a list of dental procedures that may be performed** on your child, the patient. A treatment plan will be made for your child, the patient, and presented to you after the initial examination. Prior to each appointment the specific treatment that will be performed on your child, the patient, that day will be explained to you.
    a. **Diagnostic Procedures:** Examination, radiographs (x-rays) of the teeth & jaws, consultation, photographs, dental casts.
    b. **Local Anesthesia Injection:** "Numbing medicine" carefully used to numb the teeth and surrounding areas prior to certain dental procedures such as tooth removal and dental fillings.
    c. **Dental Rubber Dam:** A sheet of latex rubber used to carefully isolate the teeth that need dental treatment.
    d. **Dental Fillings/Crowns:** Depending on the size of tooth decay, and location of tooth in the mouth, the following may be done. Front teeth: white filling/crown. Back teeth or canine teeth: silver amalgam filling or stainless steel crown.
    e. **Pulp (tooth nerve) Treatment/Root Canal:** A procedure to save baby teeth and certain permanent teeth that would otherwise be lost because of a deep cavity that has affected the tooth nerve. Saving a baby tooth that would normally be expected to remain in the mouth for nine months or more is recommended because it provides the patient with a chewing surface. Also, baby teeth serve as natural space maintainers for the adult teeth growing underneath them.
    f. **Extraction (Removal) of Teeth:** Teeth may be removed because of infection, injury, orthodontic reasons (teeth crowding), or if they are diseased and cannot be saved by any dental procedures.

**Do you wish to be contacted before procedures such as extractions? [yes] [no]**
**If we are unable to contact you and [yes] is circled we will not proceed with treatment that day.**

2. The nature and purpose of the treatment and procedures have been explained to me in general terms by the dental staff of Miles of Smiles, Ltd. Alternate procedures or methods of treatment if any, have been explained to me. I have also had the advantages, disadvantages, risks, consequences and probable effectiveness of each explained to me, as well as the prognosis if no treatment is provided.
3. I am advised that though the results of the treatment are expected to be good, the possibility and nature of complications cannot be accurately anticipated for each individual. Therefore, there can be no guarantee as expressed or implied either of the result of the treatment or of the cure.
4. **Risks and Complications:** Although their occurrence is not frequent, some **risks and complications** are known to be associated with dental or oral surgery procedures. The **more common complications** associated with special needs dental treatment include patient **biting** and **injuring** their **tongue or lip** following the administration of **local anesthesia. Less common complications** include the risks of numbness, infection, swelling, prolonged bleeding, discoloration of tissues, vomiting, allergic reactions, swallowing or aspiration of dental materials, an extracted tooth or gauze packing; injury to the tongue or lips, damage to and possible loss of existing teeth and or fillings, injury to nerves near the treatment site, and fracture of a tooth root which may require additional surgery for its removal. **For patients with certain heart diseases, the risk of Infective Endocarditis (heart infection) following certain dental procedures exists.** Therefore, antibiotics will be prescribed before the treatment, to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment that may require hospitalization.

Please initial after reading section 4: _____

5. I hereby acknowledge that I have read and understand this consent form. I have been given an opportunity to ask any questions that I might have. All questions about the procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions, which may arise during the course of my child's, the patient's, dental treatment. I also understand that I am free to withdraw my consent to treatment at any time. This consent shall remain in effect until I choose to terminate it.

Please initial after reading section 5: _____

**Do you have any objections? Yes / No**

**If yes, please explain?** _____

## DENTAL TREATMENT CONSENT AND REGISTRATION



6. -By signing this consent form, I authorize and direct the dentists of Miles of Smiles, Ltd, assisted by the dental staff of his/her choice, to perform upon my child, the patient, (or legal ward for whom I am empowered to consent) the dental treatment or oral surgery procedures explained.
   -I also hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

**-Miles of Smiles, Ltd will be at a location briefly. Because of this, MILES OF SMILES, LTD CANNOT assume the responsibility to complete the care for this child or to provide ongoing care for this child.**

**-If Miles of Smiles, Ltd begins treatment for this child and cannot complete the care within the time at your location, it is your responsibility to make other arrangements for the care of this child.**
Please initial after reading your (parent/guardian's) responsibility: _____

**-When Miles of Smiles, Ltd is at your location, the staff will try to help you find a local caregiver, but we cannot guarantee those arrangements can be made.**

Today's date: _____ Time: _____

Patient's Legal Name: _____ Date of Birth: _____

Printed Name of person completing form _____

Signature of person completing form _____

Your relationship to patient: _____

Are you the legal parent or guardian for this patient? Yes / No

Phone number(s) where you (parent/guardian) can be reached during daytime hours during our clinic days:

Cell: _____

Home: _____

Work: _____

Other emergency contact (if you cannot be reached):

Name: _____

Phone number: _____

Relationship to patient: _____

## Notice of Privacy Practices for Protected Health Information

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!**
With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.
***We may only disclose your child's health care information for purposes as you have consented; and any person/entity to whom we disclose such information will be required to consent that it will only use the information for purposes as you have consented and that it will not make any other or subsequent disclosures of that information.***

**Example of uses of your health information for treatment purposes:**
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.
**Example of use of your health information for payment purposes:**
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.
**Example of Use of Your Information for Health Care Operations:**
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.
**Your Health Information Rights** The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact **Miles of Smiles, Ltd** in person or in writing, during normal hours. They will provide you with assistance on the steps to take to exercise your rights.
**Our Responsibilities The practice is required to:**

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.
**To Request Information or File a Complaint** If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Miles of Smiles, Ltd. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Miles of Smiles, Ltd. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

**Other Disclosures and Uses**
**Notification** Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.
**Communication with Family** Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.
**Food and Drug Administration (FDA)** We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.
**Workers Compensation** If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.
**Public Health** As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
**Abuse & Neglect** We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.
**Correctional Institutions** If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.
**Law Enforcement** We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.
**Health Oversight** Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.
**Judicial/Administrative Proceedings** We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.
**Other Uses** Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.
**Website** If we maintain a website that provides information about our entity, this Notice will be on the website.
Effective Date: FEBRUARY 2012

# PARENT/GUARDIAN RELEASE
# FOR SCHOOL-BASED DENTAL TREATMENT PARTICIPATION

I, _____,

am the parent/guardian of _____

who is a student at _____School District _____.
I have consented that my child will receive screening/preventative dental care/ restorative dental care as provided by Mile of Smiles, Ltd. in consideration of its school-based dental treatment program being administered at the above mentioned school.

In consideration of the receipt of the services provided by the above mentioned program, I will not seek to have the School District held liable in the event that any accident, injury, loss of property or any other circumstance or incident occurs during or as a result of my son/daughter receiving dental treatment at school. This release of liability includes accident, injury, loss, or damages to the student, as well as, to other individuals or property which may result from the student's participation in the program. I hereby agree to release and hold the School District, its officials, agents and employees, harmless from any and all claims arising out of my son's/daughter's participation in the program.

I have read and understand and accept all of the statements recited above and accept full responsibility as described.

_____ Date:_____

Parent's/Guardian's Signature