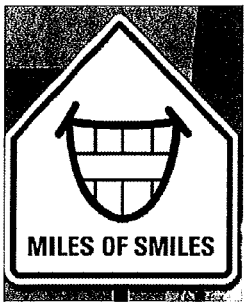


Miles of Smiles, Ltd.

Dear Parent/Legal Guardian:

Your child was recently seen at school by Miles of Smiles, Ltd. The dentist that examined your child's teeth found that further dental treatment is needed. This treatment cannot be done at school (cavities, extractions, etc).

We realize it is not always easy to get your child to a dentist (lack of transportation, time off from work, etc). So, we would like to help.

This year, Springfield Public Schools is working with Central Counties Health Centers (CCHC) to meet your child's dental needs. With parent permission your child will be transported to the CCHC dental clinic located at 2239 E Cook St in Springfield during the school day.

If you would like CCHC to transport your child from school to their clinic for the needed dental treatment, please fill-out the attached paperwork. This paperwork must be filled out and sent back to the school in order for CCHC to transport & treat your child. The transportation will be roundtrip, with your child being returned to school when treatment for that day is finished.

- **Multi-page (green cover page) consent form from CCHC (all pages must be completed)**
- **CCHC transportation consent form**
- **Copy of your child's Medical or MCO Card (copies may be made at school)**
- **Copy of Parent/Guardian's Driver's License or State I.D. (copies may be made at school)**

If you have any questions or concerns, please call our office.
Questions regarding the green consent form should be directed towards
Courtney Seitz at 217-788-2315.

Sincerely,
Dr. David R. Trost
President

2424 N 8th St. * Pekin, IL 61554-1547 * Office: 309-382-6404 * Fax: 309-382-6405

If you have any questions with this form please contact Courtney Seitz 217-788-2315.

MEDICAL AND DENTAL HISTORY FORM

Patient Name_____Date of Birth_____

Medical Doctor_____Date of Last Medical Visit_____

Reason for medical visit_____

1. Is patient currently under the care of a medical doctor?
   _____Yes _____No If yes, reason? _____

2. Is patient taking any 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 other medications? _____Yes _____No
   If yes, please state name of drug/reaction:_____

5. FEMALES: Is there any possibility patient is pregnant? _____Yes _____No
   If yes, how many months?_____ Taking birth control pills? _____Yes _____No

6. Does patient have or ever had any of the following?

	Yes	No	Comments
Heart disease, heart murmur, or heart surgery	___	___	_____
Bleeding or blood clotting problems/diseases	___	___	_____
Diabetes (blood sugar problems)	___	___	_____
Sickle cell anemia or trait	___	___	_____
Thyroid problems	___	___	_____
Convulsions/seizures or fainting spells	___	___	_____
Tuberculosis	___	___	_____
Hepatitis or other liver problems	___	___	_____
Kidney problems	___	___	_____
Asthma or wheezing	___	___	_____
Cancer, leukemia, other tumor	___	___	_____
Birth defects, or genetic defects	___	___	_____
HIV and/or AIDS	___	___	_____
Drug and/or alcohol dependency	___	___	_____
Received steroid treatment	___	___	_____
Mental retardation or delay in normal development	___	___	_____
Cigarette or smokeless tobacco use	___	___	_____

Medical History Continued

7. 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?_____

8. Has patient's doctor recommended any special precautions for dental treatment? ____Yes ____No
If yes, what precautions?_____

9. Indicate if patient has any of these: ____Blindness ____Hearing Problems ____Speech Problems

PATIENT'S DENTAL HISTORY

1. Reason you are seeking dental care for patient_____

2. Has patient ever been to a dentist before? ____Yes ____No If yes, name of dentist_____

3. Has patient ever had any of the following?	Yes	No	Comments
Injuries to the mouth or teeth?	___	___	_____
Toothache and/or abscesses?	___	___	_____

4. Does patient have any of the following habits?			
Finger, thumb or pacifier sucking?	___	___	_____
Mouth breathing?	___	___	_____

5. Do you think patient receives proper daily dental care? ___ ___ _____

6. What type of water does patient drink? ___Community tap water ___Well water ___Bottled water

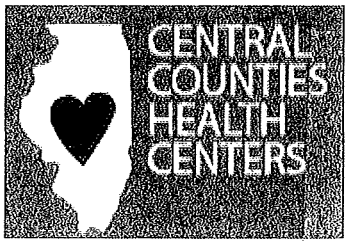
7. Other dental information we should know?_____

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.

PERSON COMPLETING THIS FORM: _____ **SIGNATURE**_____

RELATIONSHIP TO PATIENT: _____ **DATE:**_____ **TIME:**_____

Are you legally responsible for this patient? _____



If you have any questions with this form please contact al Courtney Seitz at 217-788-2315.

CONSENT AND REGISTRATION FORM

This form is to obtain your consent for dental treatment or oral surgery procedures. Please read this form very carefully and ask us about anything that you do not understand.

Dental Billing Information:

Patient Name:_____ [ ] CHECK IF SAME Guardian Name_____
Address_____ Address_____
_____ _____
City_____, IL, ZIP_____ City_____, IL, ZIP_____

Phone number(s) where you can be reached during daytime hours during our clinic days:
cell: _____
home:_____
work:_____

Medicaid: 9- Digit Medicaid Recipient ID Number ___ ___ ___ ___ ___ ___ ___ ___ ___

If you are insured through a private insurance carrier please complete this section:

Name of Private Dental Insurance Company _____ Insurance Phone Number_____
Group Number_____ Employer Name_____ Company Phone_____
Address to send Claims (on card)_____
Name of Person under whom patient is covered_____ Birth Date of Insured Adult_____
Social Security Number of insured adult_____ Contract/Policy ID number_____

(If possible attach photocopy of front and back of card)

I hereby authorize payment of dental benefits to Central Counties Health Centers for the services described.
I give my permission to the doctor to submit insurance benefit claim forms in my name and on the behalf of myself, my spouse and/ or my minor patient.

I realize that I may be responsible for and agree to pay any charges not covered by my insurance. This includes unmet deductibles, non-covered services, etc.* **Patients covered through Medicaid will not have a copay for covered procedures.*

I have received notice of privacy practices, consent to treat, and disclosure of health information. Your implied consent is acknowledged regarding disclosure of your Protected Health Information when you permit a person(s) to enter the exam room or converse with provider(s) or staff on your behalf in connection with our treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

A. Below is a list of procedures that may be performed on your patient. A treatment plan will be made for your patient and presented to you after the initial examination. Prior to each appointment the specific treatment that will be performed on your patient that day will be explained to you.

1. **Diagnostic Procedures:** Examination, radiographs (x-rays) of the teeth & jaws, consultation, photographs, dental casts.
2. **Teeth Cleaning:** Removal of soft and hard deposits on teeth, and teeth polishing with special toothpaste.
3. **Fluoride Treatment:** A solution of fluoride is placed on teeth after cleaning. Fluoride hardens the surface of teeth and helps them resist tooth decay.

4. **Dental Sealants:** Plastic sealants are applied to the grooves of the chewing surface of newly erupted permanent molar teeth to help resist tooth decay.
5. **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
6. **Dental Rubber Dam:** A sheet of latex rubber used to carefully isolate the teeth that need dental treatment.
7. **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.
8. **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.
9. **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. Parent is required to be present for extraction procedure.

B. The nature and purpose of the treatment and procedures have been explained to me in general terms by the dental staff of Central Counties Health Centers. 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.

C. 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 of either the result of the treatment or of the cure.

D. **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 **nausea** following the administrations of **topical fluoride** and a patient **biting** and injuring their **tongue or lip** following administration **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 tooth root which may require additional surgery for its removal. **For patient 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. Additional I authorize any emergency medical necessary.

_____ (initials)

E. 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 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.

_____ (initials)

. Do you have any objections? _____ Yes _____No

If yes, please explain_____

F. By signing this consent form, I authorize and direct the dentists of Central Counties Health Centers, assisted by the staff of his/her choice, to perform upon my patient (or legal ward for which I am empowered to contact) the 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 question I may have regarding this Notice.

Today's date: _____Patients Name:_____ Date of Birth:_____

Printed Name of person completing form _____

Signature of person completing form_____

Your relationship to patient: _____Are you legally responsible for this patient? _____Yes_____No

CONSENT FOR DENTAL TREATMENT

- Fill in the blanks and then turn over this Consent form
- Read and sign on the other side of this form
- Complete the Pediatric Health History Form

Return the Consent for Dental Treatment form and the Pediatric Health History Form

Child's Name:		**Birth Date:**	**Age:**
Child's Sex: ☐ Male ☐ Female	**Primary Language** ☐ English ☐ Spanish ☐ Other:	**County:** ☐ Sangamon ☐	**Race:** _Caucasion _Asian _African American _Hispanic _Indian _Other_____
Person completing this form, write in your: Name:		Relationship to this Child:	
Name of Legal Guardian		Phone Number:	
Address of Legal Guardian, incl ZIP		Home Phone:	
Does the child have a Dentist? ☐ Yes ☐ No	**If Yes:** Name of the Dentist is:		
Does the child have a Doctor? ☐ Yes ☐ No	**If Yes:** Name of the Doctor is:		

Does this child receive any of these benefits? **Check all benefits that this child receives.**

☐ All Kids ☐ Medicaid ☐ Free / Reduced School Hot Lunch

You MUST send your Medicaid card with this child to their appointment
If this child has All Kids, you Please send their All Kids card with them to their appointment so that we can bill Medicaid/All Kids for services provided.

PLEASE -- if you do not understand a question -- if you are not sure of the answer -- if you want to talk about a question with the Central Counties Heath Center staff, put a note with the Pediatric Health History form when you return the form.

- The Pediatric Health History form becomes part of this child's record with Central Counties Health Centers and is kept totally confidential.

CARE CONSENT

☐ I give my consent for a dental exam and treatment that may include x-rays, fluoride application, sealants, cleaning, topical anesthesia, local anesthesia, fillings for this child's teeth, and to take a photograph of this child's mouth. As well as any emergency care necessary.

I UNDERSTAND and CONSENT

☐ I have read and understand this Consent Form.

☐ I understand there are no guarantees about any treatment results.

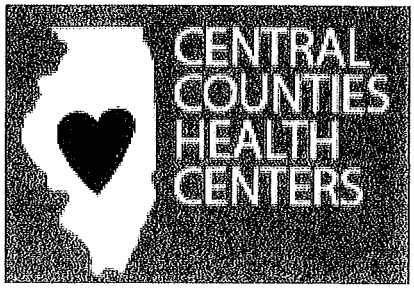
☐ I understand I am free to withdraw my consent to treatment at any time

☐ I understand this Consent for Dental Treatment shall remain in effect until I choose to end it.

☐ I have been offered a copy of Central Counties Health Center's privacy, consent to treat, pay for service and disclosure of health information notices. I understand and consent to Central Counties Health Center's privacy, consent to treat, pay for service and disclosure of health information notices.

_____ _____

Signature of Parent or Legal Guardian Date Signed



TRANSPORTATION CONSENT FORM

I hereby give my permission for my child _____ to travel by Central Counties Health Centers' transportation to _____ from_____, with drivers from Central Counties Health Centers. Permission to travel is given from _____
(DATE)
through_____.
(DATE)

In granting permission, I hereby expressly waive my claim for liability against Central Counties Health Centers, including its employees and representatives, and release them from liability in connection with this trip. Further, I assume full responsibility for any damage to persons and/or property caused by my child.

Further, in case of emergency or injury to my child, I hereby authorize Central Counties Health Centers to act in the best interest of my child. I further consent and will be responsible for any medical and/or dental treatment that may be advisable at the discretion of any physician or dentist.

It is further warranted that if this Transportation Consent Form is signed by one of two parent(s)/guardian(s), it is with the authority of the other parent/guardian.

_____ _____

Parent/Guardian Signature (REQUIRED)

Parent/Guardian Day Phone (REQUIRED)