ALL KIDS SCHOOL-BASED DENTAL PROGRAM Dental Consent Form

Rev. 06/25

PLEASE PRINT IN INK

Fill out & return to school (only if you WANT these services)

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

NAME OF SCHOOL (or Health Fair):

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/screening, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists or licensed & certified public health dental hygienists, licensed (registered) dental hygienists, and dental 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: *MM / DD / YYYY*

ADDRESS: GENDER: ☐ M ☐ F

CITY / ZIP CODE: PHONE #:

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

IF YES, INCLUDE YOUR **CHILD'S RECIPIENT ID NUMBER**: →

Medicaid/All Kids will be billed

(ID NUMBER ON BACK OF MEDI-PLAN CARD)

IS YOUR CHILD COVERED BY PRIVATE **DENTAL** INSURANCE: ☐ YES or ☐ 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** Insurnace Company:

Dental Insurance Company Address (State):

Member/employee ID or SS #: **Dental** Insurance plan or group #:

Member/employee name: **Member/employee** Birth Date:

Member's/employee's Address (if different than child's):

MEDICAL INFORMATION: Does your child have any of the following conditions? ☐ YES or ☐ NO

If yes, check all conditions that apply below:

☐ Asthma ☐ Hepititis
☐ Diabetes ☐ Epilepsy
☐ Current heart murmur
☐ Blood disorder or disease
☐ Rheumatatic fever or Rheumatic heart disease

Is an antibiotic pre-medication needed? ☐ YES or ☐ NO

Is your child taking any medications? ☐ YES or ☐ NO If yes, please list all current medications:

Does your child have a silver allergy? ☐ YES ☐ NO

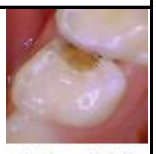
Does your child have any allergies? ☐ YES ☐ NO If yes, list all allergies:

Does you child have any other medical-related condition(s) &/or special needs? ☐ YES or ☐ NO

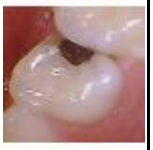
If yes, please list:

NEW: Silver Diamine Fluoride (SDF) Authorization, a new dental treatment to fight cavities!

Benefits of SDF: Dental cavities are commom in children, but now there is a safe, painless alternative to traditional cavity drilling procedures called Silver Diamine Fluoride (SDF). SDF is an FDA-approved antibiotic liquid used to help prevent cavities from forming, growing, or spreading to other teeth. SDF is applied with a brush.



Before SDF



After SDF

Alternatives:	Risks: *SDF treatment may not eliminate the need for a traditional filling;
*with no treatment, the tooth	*It's normal for SDF to stain the cavity dark, this shows it's working;
may continue to decay & cause pain;	*Healthy parts of the tooth will not be stained; *May cause a temporary metallic taste;
*other options: filling, crown, extraction.	*If contacting skin may cause temporary staining that is harmless & should disappear in a week.

I certify that I read & fully understand the information for the proposed SDF application(s). I understand the possible risks associated with SDF treatment & verify there are no contraindications for its use. **I consent to SDF application if indicated.

****SIGNATURE Consent for SDF treatment :** **DATE:**

****IMPORTANT: PARENT/GUARDIAN SIGNATURES ARE 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/DMD/PHDH INITIALS:_____ RDH INITIALS: _____