

ALL KIDS SCHOOL-BASED DENTAL PROGRAM DENTAL CONSENT FORM

Rev. 2023

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: _____

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, 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 CODE: _____ PHONE #: _____

DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS: YES / NO MCO COMPANY NAME (circle one): Aetna, BCBS, CountyCare, Meridian, Molina, YouthCare.
IS YOUR CHILD ENROLLED IN THE 'Medicaid/All Kids' PROGRAM: YES / NO Other (please list): _____

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 / 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 (State): _____

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

Member's name: _____ Member's Birth Date: _____

Member's Address (if different than child's): _____

Member's Phone # (if different than child's): _____

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	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/DMD INITIALS: _____ RDH INITIALS: _____

Child's Name: _____

Date of Birth: _____ Grade: _____

****DO NOT WRITE BELOW THIS LINE****

ALL KIDS SCHOOL-BASED DENTAL PROGRAM DENTAL RECORD

(BELOW TO BE COMPLETED BY MILES OF SMILES, LTD. DENTIST)

PRIOR TREATMENT

Restorations:

Sealants:

TREATMENT NEEDED

Restorative:

Tooth # of sealants needed; check off sealants placed today.

Sealants: ✓

Sealants: ✓

ORAL HYGIENE STATUS:	_____ Good	_____ Fair	_____ Poor
PERIODONTAL STATUS:	_____ Good	_____ Fair	_____ Poor
MALOCCLUSION:	I	II	III

(Circle one) ORAL HEALTH ASSESSMENT RATING & SCORE:



3	<u>URGENT</u> Treatment:	5+ carious lesions, gross caries, root tips, caries likely to involve pulpal tx, abscess, soft tissue pathology, pain from disease or foreign object.
2	<u>RESTORATIVE</u> Care:	4 or less cavitated, occlusal, or incipient caries. Caries not close proximity to pulpal tissue.
1	<u>PREVENTIVE</u> Care: (services rendered today)	There is no visual evidence of caries activity or periodontal pathology.

✓ TREATMENT COMPLETED TODAY (check off):

_____ EXAM

_____ PROPHYLAXIS

_____ FLUORIDE TREATMENT VARNISH / GEL

_____ SEALANTS

English:



Total sealants placed today: _____

Treatment Date: _____

Dentist's Signature: _____

Hygienist's Initials: _____

NO TX MOS yellow REFER red

Spanish:



NOTES: