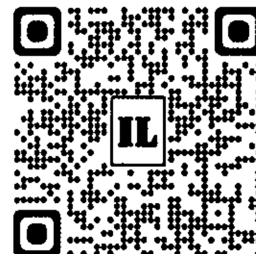
DENTAL CONSENT FORM

School ____________________ **Grade** ____________________

County ____________________ **Teacher** ____________________



Child's Name ______________________________ ☐ **Male** ☐ **Female**

Child's Birth Date _____ / _____ / _____

Cell Phone ______________________________

e-mail ______________________________

Address, City, State, Zip ______________________________

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☐ **Medicaid / All Kids** (9-digit ID# required)

SEND A PIC of Medical Card to ***MyCard@dentalsafaricompany.com***

Medical Card KidCare / All Kids Card RECIPIENT ID# __ __ __ __ __ __ __ __ __

(9-digit # on back of Card)

☐ **Private Insurance**

SEND A PIC of Insurance Card to ***MyCard@dentalsafaricompany.com***

Insurance Company Name ____________________ Employer ____________________
Primary Name ____________________ Phone ____________________
Primary Address ______________________________
Primary: Birth Date ____ / ____ / ______ Primary Soc. Sec. #: ____________________
Insurance Company Phone ____________________
Member ID#: ____________________ Group #: ____________________

☐ **Uninsured** – Reduced Fee Services. **$75** pay via PayPal on website: **www.DentalSafariCompany.com**

☐ **Provisional (Need-Based) Services** – **No Charge** – qualify for Free/Reduced Lunch AND No Insurance

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☐ **Yes** ☐ **No** **I want 6-month recall** – exam, prophy, Fluoride, sealants, SDF (topical cavity treatment)

HEALTH HISTORY – Check ALL that apply:
☐ AD/HD ☐ Blood Disorders ☐ Heart ☐ Speech Disoder ☐ Allergies ☐ Asthma ☐ Cerebral Palsy ☐ Growth Issues
☐ Pregnacy ☐ Tobacco/Drugs ☐ Autism ☐ Chronic Sinusitis ☐ Hearing ☐ Other: ____________________

Have you been told your child requires antibiotics before dental procedures ☐ Yes ☐ No
Is child allergic to ANY medication? List ______________________________
Is child taking ANY medication at this time? ______________________________

Parents/Guardian: DENTAL SAFARI COMPANY, a fully licensed, professional corporation, will be at your child's school. By signing this consent form, child receives an exam by a licensed dentist or a (PHDH) Public Health Dental Hygienist, cleaning, Fluoride, sealants and SDF (topical cavity treatment).
I give permission to treat child and understand my HIPAA rights–view at www.DentalSafariCompany.com

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PRINT NAME relation **SIGNATURE** date

ver. 10.10.23 Safari©2014 Dentist's Initials ________