DENTAL CONSENT FORM

we're on facebook

Dental Safari Company
7562 Old Rt 13
Marion, IL 62959
(618) 993-8333
(618) 993-8335 fax
contact@DentalSafariCompany.com

School _____ **Grade** _____

County _____ **Teacher** _____

Now! Can Fill Out / Submit Online!!

Parents/Guardian

DENTAL SAFARI COMPANY, a fully licensed, professional corporation, will be at your child's school. By signing this consent form, your child will receive a visual exam (no x-rays) by a licensed dentist, a cleaning, Fluoride, and sealants as needed.

ALL CHILDREN ARE ELIGIBLE. Please select the method of payment you would like to use (check one):

- ☐ Medicaid / All Kids (9-digit ID# required)
- ☐ Grant Fund – Child is on the free or reduced lunch program but has NO MEDICAL CARD #.
- ☐ Private Insurance – Most private insurance pays 100% on services we perform (questions: call (618) 993-8333)
- ☐ Cash (or Check) Payment (pick one) ☐ **Full Price** $128 [due with consent form]
- ☐ Credit Card / PayPal (go to website) ☐ **Reduced Fee** ($75 total. [due with consent form] ***Must Sign Declaration below)***

www.DentalSafariCompany.com

Cash Payment Declaration/Reduced Fee Waiver

For financial reasons, Parent/Guardian is unable to pay Full Price for dental services at this time.

_____

(print name) *signature* *date*

Child's (legal) Name _____ ☐ Male ☐ Female Birth Date ____ / ____ / _____

Address _____City_____ZIP_____Phone_____

Cell Phone:_____ **OK, to text?** ☐ Yes ☐ No **e-mail**:_____

Is Child Eligible for Free or Reduced Lunch? ☐ YES ☐ NO

Medical Card KidCare / All Kids Card RECIPIENT ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ (*9-digit # on back of Card*)

Does Your Child have PRIVATE Dental Insurance? ☐ YES ☐ NO

Primary Card Holder Name _____Phone_____ Employer _____

Primary's Address _____

Primary's: Birth Date ____ / ____ / _____; Primary's Soc. Sec. #: _____ - _____ -_ _____

DENTAL insurance company _____ Insurance Company Phone _____

Member ID#:_____; Group #: _____

☐ **YES** ☐ **NO** **NEED FOR PREMEDICATION? ** IF YES** – call (618) 993-8333
Does child need premedication **with antibiotics** for dental treatment?

HEALTH HISTORY – **PLEASE FILL OUT COMPLETELY**

Has your child had any history of the following? Check ALL that apply:

☐ AD/HD	☐ Blood Disorders	☐ Diabetes	☐ Heart	☐ Speech Issues
☐ Allergies (seasonal)	☐ Cancer	☐ Ear Aches	☐ Heart Murmur	☐ Surgeries
☐ Asthma	☐ Cerebral Palsy	☐ Growth Problems	☐ Pregnancy	☐ Tobacco/Drugs
☐ Autism	☐ Chronic Sinusitis	☐ Hearing	☐ Seizures	☐ Other

Other (checked above) Please Describe: _____

☐ **YES** ☐ **NO** **Is child allergic to ANY medication?** list _____

☐ YES ☐ NO Is child taking ANY medications at this time?

_____

☐ YES ☐ NO Has your child ever suffered injuries to the mouth, head, or teeth?

_____

☐ YES ☐ NO Does child's home have well water?

Optional: Photo/Video Release For Minor Child

_____parent/guardian

_____child

I, as parent/guardian, of the above child, give permission to Dental Safari Company to take and use pictures/videos in promotional material with no compensation to me. NOTE: Your child's name will not be used unless further permission is given.

_____

(signature)

Interested in a 6-Month Recall appointment?

This includes: dental screening, cleaning, Fluoride and sealants by a Registered Dental Hygienist.

☐ **YES** ☐ **NO** ☐ **Undecided**, need more information

IMPORTANT: Parent / Guardian Consent

I am a custodial or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment at this 6-month recall appointment.

Please Check to Certify

☐ I understand that the Dental Screening performed by Safari's Public Health Dental Hygienist does not take the place of a dental examination performed by a Dentist.

_____

signature *date*

IMPORTANT: PARENT / GUARDIAN SIGNATURE REQUIRED

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.

_____

SIGNATURE ***(RELATION TO CHILD)*** ***DATE***

* By signing, you give permission to treat your child and understand your HIPPA rights.
[HIPPA form can be reviewed at www.DentalSafariCompany.com, or a copy can be sent to you by using DENTAL SAFARI COMPANY's contact information in upper-right corner of this Consent Form]
* Also, gives HFS permission, QA Audits and providers to return to your school and re-check child's sealants.

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Dentist's Initials _____