All Kids School-Based Dental Program
Dental Exam Permission Form

DENTISTS R US, llc
1016 W. Jackson Blvd., #105
Chicago, IL 60607
(If you want DENTISTS

Please print in ink:

DENTISTS R US, llc

Name of School:_____

Teacher: _____ Grade: _____

County: _____

Dear Parent/Guardian,

DENTISTS R US,LLC, 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. *If you have a dentist, please seek similar services there.* In order for your child to receive these services in school, YOU MUST PROVIDE ALL THE INFORMATION REQUESTED BELOW AND SIGN IN THE AREA INDICATED.

YOUR CHILD'S NAME: _____ BIRTH DATE: _____ GENDER: M F

ADDRESS: _____ CITY/ZIP: _____ PHONE: _____

DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS? YES_____ NO_____

IS YOUR CHILD ENROLLED IN THE 'ALL KIDS' PROGRAM? YES_____ NO_____

IF YES, INCLUDE YOUR CHILD'S RECIPIENT ID NUMBER: _____
Nine digit ID number on back of medi-plan card

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES _____ NO _____

Name of insurance company: _____ Insurance Phone Number: _____

GROUP NUMBER: _____ EMPLOYER NAME: _____

Name of Insured: _____ Insured's Date of Birth: _____

ID # of Insured Person: _____

HEALTH HISTORY—IMPORTANT. MUST BE FILLED OUT COMPLETELY.

Has your child had any history of ANY of the following: CIRCLE ALL THAT APPLY:

Anemia Asthma Cancer Bleeding Disorder Cerebral Palsy Diabetes Fainting Epilepsy/Seizures
Kidney Disease Congenital Heart Disease Heart Murmur Latex Allergy Growth Problems Tobacco/Drug Use
Pregnancy (teen) HIV/AIDS Liver Disease/Hepatitis Thyroid Disease Joint Replacement Tuberculosis

Allergies (please list) _____

Other: _____

Does your child need pre-medication before dental treatment? YES _____ NO _____

Please list any medications your child is taking: _____

DOES YOUR CHILD HAVE ANY SPEECH DIFFICULTIES? YES _____ NO _____

HAS YOUR CHILD EVER SUFFERED INJURIES TO THE MOUTH, HEAD, OR NECK? YES _____ NO _____

WHAT TYPE OF WATER DOES YOUR CHILD DRINK? CITY _____ WELL _____ BOTTLED _____ FILTERED_____

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 representative and dental provider access to the child's dental record. I authorize DENTISTS R US, llc, to release information regarding treatment to third party payers, for the purpose of receiving payment for services, directly to DENTISTS R US, llc.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

By signing this form, you give permission to treat your child and also verify that you have received the HIPAA information provided by DENTISTS R US. This will also give permission for IDPH quality assurance audits to be performed and providers to return to your to recheck your child's sealants. I certify that I have read and understood the above information. **Dentist's Signature**: _____