Sarah Bush Lincoln
Dental Services
1-877-511-2602

FORM MUST BE TURNED IN DURING SCHOOL REGISTRATION

SCHOOL: _____

Teacher: _____ **Grade** _____

I UNDERSTAND THAT THIS FORM SERVES AS MY PERMISSION FOR MY CHILD TO RECEIVE SERVICES THROUGH YOUR DENTAL PROGRAM. THE FORM MUST BE SIGNED, DATED & RETURNED TO YOUR CHILD'S SCHOOL DURING SCHOOL REGISTRATION. ANY FORM TURNED IN AFTER THIS DATE MAY NOT RECEIVE SERVICES THROUGHOUT THE SCHOOL YEAR. YOU MAY BE CALLED SEPERATELY TO A CLINIC OUTSIDE OF OUR SCHOOL BASED PROGRAM. IT IS NOT THE RESPONSIBILITY OF THE DENTAL PROGRAM TO NOTIFY PARENT/GUARDIAN PRIOR TO THE STUDENT'S DENTAL TREATMENT AT THE SCHOOL. THIS CONSENT IS VALID FOR A PERIOD OF ONE YEAR FROM DATE OF SIGNING. THANK YOU!

Please mark one option below:

☐ **Yes,** I would like for my child to receive **ALL SERVICES** offered at his/her school. This includes dental exam, cleaning (as well as 6 month recall appointment), fluoride treatment, sealants, x-rays, fillings (white and silver), local anesthesia, nitrous oxide (laughing gas), stainless steel crowns, and extractions (tooth removal) if needed (**must have Medicaid/All Kids**).

☐ **Yes,** I would like for my child to **ONLY** receive a dental examination, cleaning (as well as 6 month recall appointment, fluoride treatment and sealants, offered at his/her school (**must be enrolled in Free/Reduced Lunch Program or have Medicaid/All Kids**).

☐ **Yes,** I would like for my child to **ONLY** receive a dental exam (anyone can receive a dental exam at no cost-**no qualifications required)**.

☐ **No,** My child receives regular dental care. I **do not wish** for my child to participate in this program (We encourage you to stay with your family dentist if you have one.)

Patient Information

Child's FULL Legal Name_____
First Name Middle Name Last Name

Sex: ☐ Male ☐ Female Age _____ Birth Date _____ Social Security # _____- _____- _____

Do you have legal custody of this child? ☐ Yes ☐ No **If NO, STOP!**

Forms must be completed by parent or legal guardian

Parent/Legal Guardian's Name_____

Address _____
Street City State Zip

Home Phone_____ Cell Phone_____ Other Phone _____ Work Phone _____

Can we leave a message regarding treatment at this number? ☐ Yes ☐ No

Is your child on the Free/Reduced Lunch Program? ☐ Yes ☐ No

Does your child have Medicaid/All Kids? ☐ Yes ☐ No If Yes, **I D Number** ___ ___ ___ ___ ___ ___ ___ ___ ___

Dental History

Does your child have a family dentist? ☐ Yes ☐ No If yes, Dentist's Name and City _____

(If you already receive regular dental care with a family dentist, please continue treatment through their office. Our program is intended for those without access to dental care.)

Has child been seen in the last 12 months? ☐ Yes ☐ No If yes, when _____

What services were performed? _____

Does your child have any dental problems/complaints?

_____

Has your child been informed by a physician due to a medical condition that he/she needs to take an antibiotic before their dental treatment? ☐ Yes ☐ No If Yes, please explain_____

Medical History

Child's Doctor_____ City/State_____ Phone_____

Is child under the care of a doctor now? ☐ Yes ☐ No
If yes, please explain_____

Ever been hospitalized ☐ Yes ☐ No
If yes, please explain_____

Is child receiving any medication? ☐ Yes ☐ No

Ever had surgery? ☐ Yes ☐ No If yes, why?_____

If yes, list current medications, including over-the-counter and herbal:_____ _____

Preferred Pharmacy_____ Phone Number_____

If necessary, do you give permission for SBL Dental Services to administer Tylenol or Motrin to your child before/after restorative treatment?
Tylenol ☐ Yes ☐ No Motrin ☐ Yes ☐ No

Is your child allergic to any foods, medications, environmental allergens, or other? ☐ Yes ☐ No
Please list known allergies_____

HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CIRCLE

AIDS/HIV	**Cerebral Palsy**	**Fainting/ Dizzy Spells**	**Tumors/Growths**	**Mental Health**
ADD/ADHD	**Cognitive Disorders**	**Heart Disease**	**Pregnancy**	**Mental Disorders**
Anemia	**Communication Disorders**	**Hemophilia**	**Respiratory Care/Disease**	**Hearing Problems**
Artificial Heart Valves	**Developmental Disability**	**Hepatitis**	**Rheumatic Fever**	**Cancer**
Asthma	**Diabetes**	**Implants**	**Rheumatism/Arthritis**	**Tuberculosis**
Behavioral Disorders	**Donor Organs**	**Intestinal Disease**	**Seizures**	**Blood Transfusion**
Blood Disorders/Disease	**Drug/Alcohol Abuse**	**Joint Replacement**	**Sexually Transmitted Diseases**	**Liver Disorder/Disease**
Blood Pressure High	**Emotional Disorders**	**Kidney Disease**	**Sickle Cell Anemia**	**Stomach Disease**
Blood Pressure Low	**Epilepsy**	**Latex Allergy**	**Heart Murmur (if yes, please explain below)**	

Other: _____

Emergency Information

In the event of an emergency, whom should we contact (**other than yourself**)?

Name_____Relationship_____Phone_____

Consent and Authorization

-I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge.
-I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for my child.
-I give consent to the dental staff to perform any necessary dental services my child will need.
-I agree to notify the dentist if any change in my child's health status should occur.
-I understand that Sarah Bush Lincoln Dental Services must at times collaborate with other outside facilities to coordinate treatment and hereby authorize release of protected health information to these facilities when necessary for treatment of my child.
-I authorize the dentist to release all protected health information necessary to secure payment of benefits to Medicaid of Illinois.

Signature of Parent/Guardian_____ **Date**_____