SARAH BUSH LINCOLN DENTAL SERVICES
225 RICHMOND AVE. E STE. B
MATTOON, IL 61938
P: (217) 235-0800 | F: (217) 235-0801

All Services School-Based Care Consent

Thank you for choosing Sarah Bush Lincoln to provide your child's oral health care. We sincerely appreciate the opportunity to be of service to you. Listed below is important information about our office and policies.

SCHOOL: _____ **TEACHER:** _____ **GRADE:** _____

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, fluoride treatment, local anesthesia, sealants, X-Rays, fillings (white and silver), stainless steel crowns, extractions (tooth removal), and nitrous oxide (laughing gas) if needed.
  Qualifications: Must have Medicaid/All Kids or qualify for Free/Reduced Meals
- ◯ Yes I would like for my child to receive **PREVENTATIVE SERVICES ONLY** offered at his/her school. This includes dental exam, cleaning, fluoride treatment and sealants (if needed).
  Qualifications: Must have Medicaid/All Kids or qualify for Free/Reduced Meals
- ◯ Yes I would like for my child to **ONLY** receive a dental exam.
  Qualifications: none
- ◯ No 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!

PAIN CONTROL

If necessary, do you give permission for SBL Dental Services to administer Tylenol or Motrin to your child before/after treatment?

Tylenol: ☐ Yes ☐ No Motrin: ☐ Yes ☐ No

DENTAL PHOTOGRAPHY

I authorize SBL Dental Services to take photographs, and/or videos of the patient's face, jaws, and teeth; this may include before, during and after treatment. The photographs will be used for the following: dental records, dental research, dental education (including lectures, seminars, demonstrations, professional publications, printed materials for patient education), and marketing materials including websites. The photographs and/or videos that are used along with the patient's name or any other identifying information will be kept confidential. There will be no compensation, financial or otherwise, for the use of these photos.

◯ I authorize ◯ I do not authorize

AUTHORIZATION FOR GENERAL TREATMENT & ACKNOWLEDGEMENT OF RESPONSIBILITY

- I affirm that I am a legal guardian or representative for the patient named on this form.
- I affirm the information I have given is correct to the best of my knowledge. This information will be held in confidence, and it is my responsibility to inform this office of changes in my child's medical status, guardian status, and/or residential information.
- I acknowledge that I have been provided the opportunity to review the Joint Notice of Privacy Practices.
- I understand that it is not the responsibility of the dental program to notify the parent/guardian prior to the student's dental treatment at the school.
- I understand that communication is through paperwork sent home with my child.
- I give consent to the dental staff to perform any necessary dental services my child will need.
- 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 Sarah Bush Lincoln Dental Services to release all protected health information necessary for proof of dental exam and/or necessary medical treatment to my child's school.
- I authorize Sarah Bush Lincoln Dental Services to release all protected health information necessary to secure payment of benefits to Medicaid of Illinois.

CHILD'S Legal Name: _____ _____

First Name Middle Name Last Name **Date of Birth**

GUARDIAN'S Signature: _____ **Date**: _____ **Time**: _____

SARAH BUSH LINCOLN DENTAL SERVICES
225 RICHMOND AVE. E STE. B
MATTOON, IL 61938
P: (217) 235-0800 | F: (217) 235-0801

Please tell us about your child…

CHILD'S Legal Name_____
First Name Middle Name Last Name

Sex: ◯ Male ◯ Female Age _____ Date of Birth _____

Race: ◯ Black ◯ Latino ◯ Asian ◯ White/Non-hispanic ◯ Multiracial ◯ Other:_____ ◯ Prefer not to answer

Address _____
Street City State Zip

Who does patient live with? _____
Preferred language: ◯ English ◯ Spanish ◯ Other
School: _____

Is your child in the Free/ Reduced Lunch Program? ◯ Yes ◯ No
Does your child have Medicaid/ All Kids? ◯ Yes ◯ No If yes, ID Number ___ ___ ___ ___ ___ ___ ___ ___ ___

Please tell us about your child's family…

GUARDIAN'S Name _____
First Name Middle Name Last Name

Address _____
Street City State Zip

Please provide all contact information and select one as your primary choice for correspondence:
◯ Home Phone: _____
◯ Cell Phone: _____
◯ Other Phone: _____

Relationship to Patient: _____

Preferred language: ◯ English ◯ Spanish ◯ Other: _____
Marital Status: ◯ Divorced ◯ Married ◯ Single ◯ Widowed

Please provide name and contact information for other parents, legal guardians and siblings:

	Name	Phone
◯ Guardians:	_____	_____
◯ Siblings:	_____	_____
◯ Other:	_____	_____

Emergency Contact (other than yourself):

Name: _____ Relationship: _____ Phone: _____

Patient Name: _____ DOB: _____ Date: _____

Primary Care Physician: _____
Physician Address: _____
Physician Phone: _____
Date of Last Medical Exam: _____

Previous Dentist: _____
Dentist Phone: _____
Last Dental Visit: _____
Last Dental X-Rays: _____

Dental History:

Does the patient have any dental concerns or questions? _____

Is the patient in pain? ◯ Yes ◯ No Explain: _____

Has patient had an injury to the mouth, teeth, or jaw? ◯ Yes ◯ No Explain: _____

Does the patient have dental anxiety? ◯ Yes ◯ No Explain: _____

Medical History:

Is patient currently under the care of a physician? ◯ Yes ◯ No Explain: _____

Does patient have allergies? ◯ Yes ◯ No Explain: _____

Is patient taking medications or herbal supplements? ◯ Yes ◯ No Please list below.

Medication Name:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has patient had surgery or been hospitalized? ◯ Yes ◯ No

Hospital:	When:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does patient have/or had any of the following:

Yes / No		Yes / No		Yes / No	
◯	◯ Congenital Heart Disease/Defect	◯	◯ Visual/Hearing Impairment	◯	◯ Eating Disorders
◯	◯ Heart Surgery	◯	◯ Abnormal Bleeding Issues	◯	◯ Mental Health Disorders
◯	◯ Heart Murmur/Disease	◯	◯ Sickle Cell Trait/Disease	◯	◯ Cancer
◯	◯ High Blood Pressure	◯	◯ Hemophilia/Anemia	◯	◯ Tumors/Growths
◯	◯ Rheumatic Fever	◯	◯ Blood Transfusion	◯	◯ Pregnancy
◯	◯ Asthma/Breathing Issues	◯	◯ Kidney Problems	◯	◯ Hepatitis A, B, C
◯	◯ Cerebral Palsy	◯	◯ Liver Problems	◯	◯ HIV/AIDS
◯	◯ Seizures/Convulsions/Epilepsy	◯	◯ Diabetes	◯	◯ Drug/ Alcohol Abuse
◯	◯ Learning/Communication Problems	◯	◯ Muscle/Joint/Bone Problems	◯	◯ MRSA
◯	◯ Behavioral Disorders	◯	◯ Thyroid/Glandular Problems	◯	◯ TB/Tuberculosis
◯	◯ Autism	◯	◯ Skin Problems/Hives/Cold Sores	◯	◯ Limited Mobility
◯	◯ ADD/ADHD	◯	◯ Stomach/Intestinal Disease	◯	◯ Other: _____

I affirm that the information provided above is correct to the best of my knowledge. This information will be held in confidence, and it is my responsibility to inform this office if there is a change to the health history of this patient. I authorize the release of this information to additional healthcare providers as is necessary for the dental treatment of this patient.

GUARDIAN'S Signature: _____ **DATE**: _____ **TIME**: _____

Dentist's Signature: _____ Date: _____ Time: _____

SUBMIT