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

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: _____ (if PK- AM or PM)

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, sealants, silver diamine fluoride (SDF), and x-rays if needed.
Qualifications: Must have Medicaid/All Kids or QUALIFY for Free/Reduced Meals or no private dental insurance coverage

☐ 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!

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. This may include Sarah Bush Lincoln volunteer dentists and public health dental hygienists. This will also give permission for the Illinois Department of Public Health to provide quality assurance audits by evaluating your child's dental services performed at the school. Upon determination, this permission will allow for any dental work to be redone or replaced by the provider if indicated.
- 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**

Sex: ☐ Male ☐ Female Age _____ Who does patient live with? _____

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

GUARDIAN'S Legal Name _____

Relationship to Patient: _____

Address _____
Street City State Zip

Please provide all contact information:

☐ Home Phone: _____ ☐ Cell Phone: _____ ☐ Other Phone: _____

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Widowed

PLEASE TURN OVER AND COMPLETE BACK SIDE →

Does your child have Private Dental Insurance? ☐ **Yes** ☐ **No**
Is your child QUALIFY for the Free/ Reduced Lunch Program? ☐ **Yes** ☐ **No**
Does your child have Medicaid/ All Kids? ☐ **Yes** ☐ **No** **If yes, ID Number** __ __ __ __ __ __ __ __ __

Emergency Contact (**other than yourself**):

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

CHILD'S Primary Care Physician: _____

CHILD'S Previous Dentist: _____ Last Dental Visit: _____

Dental History:
Is the patient in pain OR have any concerns or questions? ☐ Yes ☐ No Explain: _____
Has patient had an injury/trauma to the mouth, teeth, or jaw? ☐ Yes ☐ No Explain: _____
Does the patient have dental anxiety? ☐ Yes ☐ No Explain: _____

MEDICAL HISTORY: PLEASE CHECK THE BOX IF YOUR CHILD:
If you DO NOT check the box in the medical history portion of this form, it will indicate that the question or medical condition DOES NOT apply to your child. If you mark the box and do not explain, your child may not receive services.

Has any known allergies? ☐ **If box is checked, must explain:** _____
Takes any medications or herbal supplements? ☐ **If box is checked, must explain:** _____

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

Has your child had surgery or been hospitalized? ☐ **If box is checked, must list surgeries/hospitalizations below:**

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

PLEASE CHECK THE BOX IF YOUR CHILD HAS OR HAS HAD ANY OF THE FOLLOWING:

☐ Congenital Heart Disease/Defect	☐ Heart Murmur/Disease	☐ Anemia
☐ Heart Surgery	☐ High Blood Pressure	☐ Liver Problems
☐ Seizures/Convulsions/Epilepsy	☐ Rheumatic Fever	☐ Diabetes
☐ Abnormal Bleeding Issues	☐ Asthma/Breathing Issues	☐ Muscle/Joint/Bone Problems
☐ Hemophilia	☐ Cerebral Palsy	☐ Skin Problems/Hives/Cold Sores
☐ Blood Transfusion	☐ Learning/Communication Problems	☐ Stomach/Intestinal Disease
☐ Thyroid/Glandular Problems	☐ Behavioral Disorders	☐ Eating Disorders
☐ Cancer	☐ Autism	☐ Mental Health Disorders
☐ Tumors/Growths	☐ ADD/ADHD	☐ Drug/Alcohol Abuse
☐ Pregnancy	☐ Visual/Hearing Impairment	☐ MRSA
☐ Hepatitis A, B, C	☐ Sickle Cell Trait/Disease	☐ Limited Mobility
☐ HIV/AIDS	☐ Kidney Problems	☐ Other: _____
☐ TB/Tuberculosis	☐ Organ Transplant	

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.

FORM MUST BE SIGNED BY LEGAL GUARDIAN IN ORDER FOR THE CHILD TO RECEIVE TREATMENT.

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

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