



# 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 **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 Dr. Marlee Hansen 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:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Does patient have/or had any of the following:

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