DENTAL CONSENT FORM

Dental Safari Company
7562 Old Rt 13
Marion, IL 62959
(618) 993-8333
(618) 993-8335 fax
contact@DentalSafariCompany.com

School ______________________ Grade __________
County ______________________ Teacher ______________________

Now! Can Fill Out / Submit Online!!

Parents/Guardian: DENTAL SAFARI COMPANY, a fully licensed, professional corporation, will be at your child's school.
By signing this consent form, child receives an exam by a licensed dentist, cleaning, Fluoride, sealants and SDF caries treatment

Is Child at school? ☐ **100% e-learning** *(at home)* ☐ **Blended** *(check days at school)* ☐Mon ☐Tues ☐Wed ☐Thur ☐Fri
Is Child returning patient ☐ Yes ☐ No
Do you want Child to have appropriate dental x-rays? ☐ Yes ☐ No

Child's Name ______________________ ☐ Male ☐ Female Birth Date ____ / ____ / _____

Address ______________________ City ____________ ZIP __________ Phone ______________

Parent/Guardian Cell Phone: ______________ **OK, to text?** ☐ Yes ☐ No **e-mail:** ______________________

Please select the METHOD OF PAYMENT you would like to use (check one):

☐ Medicaid / All Kids (9-digit ID# required)
☐ Private Insurance – Most private insurance pays 100% on services we perform (questions: call (618) 993-8333)
☐ Self-Pay - Credit Card / PayPal (go to website) www.DentalSafariCompany.com
- ☐ Full Price $128 [due with consent form]
- ☐ Reduced Fee ($75 total. [due with consent form] *Must Sign Declaration below)*

* If you prefer Cash / Check Please call our office to arrange. (618) 993-8333

Cash Payment Declaration/Reduced Fee Waiver
For financial reasons, Parent/Guardian is unable to pay Full Price for dental services at this time.

(print name) ______________ *signature* ______________ *date* ______

☐ Grant Fund – Child is ON FREE OR REDUCED LUNCH PROGRAM but has NO MEDICAL CARD #.

~~(9-digit # on back of Card)~~

Is Child Eligible for Free or Reduced Lunch? ☐ YES ☐ NO
Medical Card KidCare / All Kids Card RECIPIENT ID# __ __ __ __ __ __ __ __ __

Does Your Child have PRIVATE Dental Insurance? ☐ YES ☐ NO Employer ______________
Primary Card Holder Name ______________________ Phone ______________
Primary's Address ______________________
Primary's: Birth Date ____ / ____ / ______; Primary's Soc. Sec. #: _____ - _____ - ______
DENTAL insurance company ______________ Insurance Company Phone ______________
Member ID#: ______________________; Group #: ______________

Optional: Photo/Video Release For Minor Child

______________ parent/guardian

______________ child

I, as parent/guardian, of the above child, give permission to Dental Safari Company to take and use pictures/videos in promotional material with no compensation to me. NOTE: Your child's name will not be used unless further permission is given.

____
signature

HEALTH HISTORY – PLEASE FILL OUT COMPLETELY

Has your child had any history of the following? Check ALL that apply:

☐ AD/HD	☐ Blood Disorders	☐ Diabetes	☐ Heart	☐ Speech Difficulties
☐ Allergies (seasonal)	☐ Cancer	☐ Ear Aches	☐ Heart Murmur	☐ Surgeries
☐ Asthma	☐ Cerebral Palsy	☐ Growth Problems	☐ Pregnancy	☐ Tobacco Drug Use
☐ Autism	☐ Chronic Sinusitis	☐ Hearing	☐ Seizures	☐ Other

Other (checked above) Please Describe: ______________________

☐ YES ☐ NO Have you been told your child requires antibiotics before dental procedures due to a medical condition?
☐ YES ☐ NO Is child allergic to ANY medication? list ______________
☐ YES ☐ NO Is child taking ANY medications at this time? ______________
☐ YES ☐ NO Has your child ever suffered injuries to the mouth, head, or teeth? ______________
☐ YES ☐ NO Does child's home have well water? ______________

Interested in a 6-Month Recall Appointment?

This includes dental screening, cleaning, Fluoride and sealants by a Registered Dental Hygienist.

☐ YES ☐ NO ☐ I need more information

IMPORTANT: Parent / Guardian Consent

I am a custodial or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment at this 6-month recall appointment.

____
signature *date*

IMPORTANT: 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/nurse representative and dental provider access to child's dental record. *By signing, you give permission to treat your child and understand your HIPPA rights – which can be reviewed at www.DentalSafariCompany.com. Also, this gives permission for HFS, QA Audits and providers to return to your school and re-check your child's sealants.*

____
PRINT NAME relation SIGNATURE date

Dentist's Initials ______

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