PLEASE MARK

☐ YES

☐ NO

Español
Reverso

DENTAL SCREENING CONSENT FORM

Dear Parent or Guardian-ONSITE DENTAL has partnered with our school to arrange for preventive dental services for eligible children. These services may include an exam, cleaning, fluoride treatment, sealants (a protective coating on the chewing surfaces of back teeth) and dental education. Licensed dentists, hygienists and assistants will come to your child's school with portable dental equipment during the school day. In order for your child to receive these services you must provide all the information requested below and sign in the area indicated. Please note: As of August 2015, some dental insurance plans may only cover cleanings and fluoride treatments once per every six months regardless of place of service.

If you are not interested in this program, please print your child's name, GRADE, and date of birth, and check "NO" on the top of this form.

Child's Name: (Last, First name)	Male ___ Female ___	D.O.B. (MM/DD/YYYY)	
Home Phone:	Cell Phone:	Work Phone:	
Email: ____________________@____________________ (Please print very neatly)			
Address:	City:	Zip:	County:
School:	Grade:		
Teacher:	Preferred Language:		

Does your child have any medical history that may complicate dental treatment?

Does your child qualify for free/reduced meals? YES ____ NO ____

Is your child enrolled in the "ALL KIDS" Program (Public Aid /Medicaid/Kid Care)? YES ____ NO ____

If yes, please include your child's Medical Card ID Number:

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Is your child covered by private dental insurance? Yes _____ No______

For information on how to use private dental insurance please visit our website: www.onsite-dental-services.com

In signing this form, you give permission for your child to be treated by Onsite Dental. Your signature also verifies that you have read the attached form regarding HIPAA. This consent gives permission for: Onsite Dental and your child's school to mutually share this consent form, for Illinois Dept of Public Health to provide Quality Assurance checks where officials may return to your school and re-check your child's sealants, and also allows the school to release address and telephone information as well as school directory information such as classroom and daily schedule information as necessary to Onsite Dental. I understand that some dental plans may only cover cleanings and fluoride treatments every six months regardless of place of service, I hereby authorize payment of dental benefits for the services described. I give my permission to the doctor to submit insurance benefit claim forms in my name and on behalf of myself, my spouse and/ or my minor patient.

Signature:	Date:
Are you legally responsible for this child? Yes / No	Relationship: