DENTAL CONSENT FORM

School _____ **Grade** _____

County _____ **Teacher** _____

Child's Name _____ ☐ **Male** ☐ **Female**

Child's Birth Date _____ / _____ / _____

Cell Phone _____ **e-mail** _____

Address, City, State, Zip _____

_____

☐ **Medicaid / All Kids** (9-digit ID# required)

SEND A PIC of Medical Card to ***MyCard@dentalsafaricompany.com***

Medical Card KidCare/All Kids Card RECIPIENT ID# ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ **Private Insurance** (*9-digit # on back of Card*)

SEND A PIC of Insurance Card to ***MyCard@dentalsafaricompany.com***

DENTAL Insurance Company Name _____ Employer _____

Primary Name _____ Phone _____

Primary Address _____

Primary: Birth Date ____ / ____ / _____ Primary Soc. Sec. #: _____

Insurance Company Phone _____

Member ID#: _____ Group #: _____

☐ **Uninsured** – Reduced Fee Services. **$75** pay via PayPal on website: **www.DentalSafariCompany.com**

☐ **Provisional (Need-Based) Services** – **No Charge** – qualify for Free/Reduced Lunch AND No Insurance

HEALTH HISTORY – Check ALL that apply:

❑ AD/HD ❑ Blood Disorders ❑ Heart ❑ Speech Disorder ❑ Allergies ❑ Asthma ❑ Cerebral Palsy ❑ Growth Issues
❑ Pregnancy ❑ Tobacco/Drugs ❑ Autism ❑ Chronic Sinusitis ❑ Hearing ❑ Other: _____

Have you been told your child requires antibiotics before dental procedures ❑ Yes ❑ No

Is child allergic to any medication? _____

Is child taking any medication at this time? _____

CHECK ALL THE WAYS we can communicate with you: ☐ Call ☐ Text ☐ e-mail

List any Individuals / Relatives that we can communicate with regarding child's dental healthcare:

_____ _____ _____

☐ By checking, I **ALSO CONSENT to restorative care which may include:** appropriate fillings, crowns, pulpotomies, baby teeth extractions (with or without space maintainers)

Comments / Concerns:

Parents/Guardian: DENTAL SAFARI COMPANY, a fully licensed, professional corporation, will be at your child's school. By signing this consent form, my child receives an exam by a licensed dentist or a (PHDH) Public Health Dental Hygienist, possibly x-rays, cleaning, Fluoride, sealants and SDF (topical cavity treatment) up to two times during the school year. *I give permission to treat child and understand my HIPAA rights–view at www.DentalSafariCompany.com.* I also grant permission for IPDH oral health consultants to perform sealant rechecks up to a year after the sealant is placed.

PRINT NAME relation **SIGNATURE** date

Dentist's Initials _____