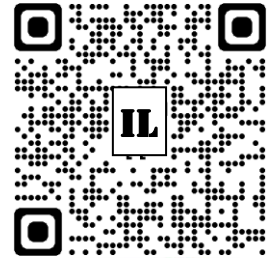


# DENTAL CONSENT FORM



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](mailto: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](mailto: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](http://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](http://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 \_\_\_\_\_