Dental SAFARI Company

We Are Coming To Richland County Schools!!

March 29-31, 2021

- ✓ Exam
- ✓ Cleaning
- ✓ Fluoride
- ✓ Sealants

www.DentalSafariForms.com

Takes about two minutes.

Or Scan:

DENTAL CONSENT FORM

we're on facebook

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, your child receives an exam (no x-rays) by a licensed dentist, cleaning, Fluoride, and sealants as needed.

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 #.

Is Child Eligible for Free or Reduced Lunch? ☐ YES ☐ NO
Medical Card KidCare / All Kids Card RECIPIENT ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ (*9-digit # on back of Card*)

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 #: _____

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?

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

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)

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*

Dentist's Initials _____