ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

PLEASE PRINT IN INK

DENTAL EXAM

Services Rendered By:

THE TRAVELING TOOTH FAIRY
ON A MISSION FOR HEALTHY SMILES
(847) 305-4880
1212 S Naper Blvd, Suite #119-177
Naperville, Illinois 60540

NAME OF SCHOOL:_____

TEACHER:_____ GRADE: _____

COUNTY:_____

DO YOU HAVE A DENTIST? YES / NO **DENTIST'S NAME:** **EXAM DATE:**

PROVIDE THE FOLLOWING INFORMATION ONLY IF YOU WANT THESE DENTAL SERVICES to be rendered by The Traveling Tooth Fairy at school.

Dear Parent or Guardian,

The Traveling Tooth Fairy. and The Illinois Department of Healthcare and Family Services have arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists, and assistants will come to your child's school with portable equipment. In order for your child ***to receive these services***, you must **PROVIDE ALL THE INFORMATION** REQUESTED BELOW **AND SIGN** IN THE AREA INDICATED.

YOUR CHILD'S LEGAL NAME:_____BIRTH DATE: _____/_____/_____

ADDRESS:_____ GENDER: M / F / NB

CITY/ZIP:_____ HOME PHONE: _____-_____-_____

DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS: YES / NO

IS YOUR CHILD ENROLLED IN THE 'Medicaid/All Kids' PROGRAM: YES / NO

MCO COMPANY NAME (if not listed): _____

MCO COMPANY NAME (circle one):
Aetna BCBS Meridian

IF YES, INCLUDE YOUR **CHILD'S RECIPIENT ID NUMBER**: → _____ _____ _____ _____ _____ _____ _____ _____ _____

Medicaid/All Kids will be billed

(9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD)

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES / NO (if incomplete, only grades K, 2nd, & 6th may be eligible for an exam)

If YES, please fill out **ALL** the insurance information below: ***(DENTAL INSURANCE COMPANY WILL BE BILLED)***

Name of Dental Insurance Company:_____

Dental Insurance Company Address:_____

Member's (employee) ID *or* SS #:_____ **Dental Insurance plan or group number**: _____

Member's name:_____ **Member**'s Birth Date:_____

Member's Address *(if different than child's)* :_____

Member's Phone Number *(if different than child's)* :_____ Employer:_____

Has your child had any history of, or conditions related to, any of the following: (Please circle)							
Anemia:	YES / NO	Chronic Sinusitis:	YES / NO	Growth problems:	YES / NO	Seizures:	YES / NO
Asthma:	YES / NO	Diabetes:	YES / NO	Hearing:	YES / NO	Thyroid:	YES / NO
Bleeding disorders:	YES / NO	Ear aches:	YES / NO	Heart Disease:	YES / NO	Tobacco / drug use:	YES / NO
Cancer:	YES / NO	Epilepsy:	YES / NO	Latex allergy**:	YES / NO	Allergies:	
Cerebral Palsy:	YES / NO	Fainting:	YES / NO	Pregnancy (teens):	YES / NO	Other:	
Is your child taking any prescription and/or over the counter medications at this time? YES / NO If yes, please list:							
Does you child have any known heart condition? YES / NO DESCRIBE:							
Does your child have any artificial joints: YES / NO IF YES, WHEN & WHAT JOINT:							
Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? YES / NO IF YES, WHAT:							

IMPORTANT: PARENT/GUARDIAN SIGNATURE REQUIRED *(ONLY IF YOU WANT THESE SERVICES)*

I am a custodial parent or legal guardian of the above minor child. I authorize and consent to this child receiving the dental treatment described and allow the school nurse/school representative and dental provider access to the child's dental record. This will also give permission for the Illinois Department of Public Health to provide quality assurance audits by evaluating your child's dental services performed at the school. Upon determination, this permission will allow for any dental work to be redone or replaced by the provider if indicated. To the extent permitted by law, I consent to the use and disclosure of the minor child's protected health information to carry out payment activities in connection with this claim. I hereby authorize and direct payment of the dental benefits to The Traveling Tooth Fairy, LLC (TTTF). This also gives permission for TTTF to come back this school year and provide a possible prophy and fluoride treatment for your child.

SIGNATURE: **PRINT NAME:** **DATE:**

Please continue to see your regular dentist for your complete oral health.

DDS INITIALS_____RDH INITIALS_____