

**Authorization for Dental Exam and Treatment by Children's Dental Services**

**\*\*Note: Please fill out the medical history and consent form for your child on the back of this form. If this form is not filled out completely, it will delay services. If you have any questions about the form, please call CDS at 612-746-1530.**

Dear Parent/Guardian:

Children's Dental Services (CDS) is providing dental care for children at your child's school. Most routine dental treatments can be done at school, including examinations, x-rays, cleanings, fluoride treatments, plastic sealants. If patients are in need of: fillings, crowns, extractions or other treatments, they can be referred to a local provider, a clinic of the family's choice, or one of CDS's mobile clinics. Patients that are referred to a local provider will have their contact information and dental diagnosis shared to ensure their dental health needs are met

If your child has his/her own dentist and you do not wish care from CDS, please do not return the form to your child's school.

Student's Name (print) \_\_\_\_\_ Birth Date \_\_\_\_\_

Student's Soc.Sec.No \_\_\_\_\_ Gender: Male Female

Parent's Names (print) \_\_\_\_\_

Parent's e-mail address: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Child's School \_\_\_\_\_ Grade \_\_\_\_\_ Room \_\_\_\_\_

**Insurance:**

1) Does the patient have insurance through the state? i.e Medical Assistance (circle one) **YES** or **NO**. If yes what is member # or PMI# \_\_\_\_\_

2) Does the patient have insurance through parent's employer or other discount program? (circle one) **YES** or **NO**. If yes fill in information below.

Name of Dental Insurance/Discount Plan \_\_\_\_\_

Policy Holder's Name/Name of Employee \_\_\_\_\_ Date of birth \_\_\_\_\_

Dental Plan Identification Number or Social Security No \_\_\_\_\_

Dental Plan Phone Number \_\_\_\_\_

**\*Please enclose a front and back copy of insurance or discount card**

**\*Children's Dental Services accepts all forms of Public and Private Insurance (i.e Medical Assistance)**

Date of Child's Last Dental Visit \_\_\_\_\_ Dentist's Phone No. \_\_\_\_\_

I give permission for CDS to bill my insurance for any services provided to me or my child and I understand that I am responsible for any amount not covered by the insurance.

**Children's Dental Services Authorization for Dental Exam and Treatment:** I give permission for CDS to provide a dental exam and preventative services. Specifically I consent to routine dental treatments being performed on my child, including examinations, cleaning, fluoride, and plastic sealants. I understand that with any procedure there are associated risks, but that these risks are often outweighed by the benefits of such treatment

**If I had any further questions about these risks and benefits of treatment or alternate treatment options I have contacted a Dentist at CDS to ask such questions and they have been answered adequately. I have had adequate time to make the decision to give consent freely.**

**This consent form is valid for one year from the date signed unless revoked in writing to Children's Dental Services.**

**Parent or Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**\*Note:** If your child is seen by one of CDS' hygienists this does not take the place of a visit to the dentist; we recommend that you have your child seen for an exam by a dentist within 6 months if he/she has not already done so

Name of patient: \_\_\_\_\_ Date of birth: \_\_\_\_\_

1. Have you seen a physician within the past 2 years? Y      N  
If yes, for what problem? \_\_\_\_\_
2. Please give the name, address and phone number of your regular physician:  
\_\_\_\_\_
3. Have you been a patient in a hospital within the past 2 years? Y      N  
If yes, for what problem? \_\_\_\_\_
4. Circle any of the following which you have had or have at present:
- |                          |                                 |  |
|--------------------------|---------------------------------|--|
| heart failure            | chronic cough                   | persistent diarrhea                                  |
| heart disease or attack  | tuberculosis (TB)               | hepatitis  |
| angina pectoris          | asthma                          | liver disease  |
| high blood pressure      | hay fever                       | yellow jaundice                                      |
| heart murmur             | sinus trouble                   | blood transfusion                                    |
| rheumatic fever          | allergies or hives              | drug addiction                                       |
| congenital heart lesions | diabetes                        | hemophilia   |
| artificial heart valve   | thyroid disease                 | venereal disease (syphilis, gonorrhea,<br>chlamydia) |
| heart pacemaker          | x-ray or cobalt treatment       | genital herpes                                       |
| heart surgery            | chemotherapy (cancer, leukemia) | cold sores or fever blisters                         |
| artificial joint         | arthritis                       | epilepsy or seizures                                 |
| anemia                   | cortisone medicine              | fainting or dizzy spells                             |
| stroke                   | glaucoma                        | nervousness  |
| kidney trouble           | AIDS                            | psychiatric treatment                                |
| ulcers                   | HIV                             | sickle cell disease                                  |
| emphysema                | white or blue patches in mouth  | enlarged "glands" or lymph nodes                     |
| developmental disability |                                 |  |
5. Do you have any disease, condition, or problem not listed? Y      N  
If yes please list \_\_\_\_\_
6. Have you ever had any operations or surgery? Y      N  
If yes, what was the problem? \_\_\_\_\_  
Any complications? (describe) \_\_\_\_\_
7. Have you ever had any excessive bleeding requiring special treatment? Y      N
8. Are you taking any medicines, drugs, herbal supplements or vitamins? Y      N  
If yes, what kind? \_\_\_\_\_
9. Do you have any allergies to drugs or medicines? Y      N  
If yes, to what and how do you react? \_\_\_\_\_
10. When was your last dental visit? \_\_\_\_\_
11. Have you ever had any unusual reaction to a dental anesthetic? Y      N
12. **Women:** Are you pregnant now? Y      N  
Do you think you might be pregnant? Y      N  
When is your due date? \_\_\_\_\_
13. What is the patients race/ethnicity? \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature