Children's Dental Services

636 Broadway Street NE
Minneapolis, MN 55413
Tel: 612-746-1530
Fax: 612-746-1531

Experts say tooth decay is the most chronic childhood disease, and over 50 percent of low-income children in Minnesota are not receiving dental care. That's why Children's Dental Services (CDS) and Brooklyn Center schools are working to provide dental care within the district. This program provides dental care to children from birth until the age of twenty-one if the patient is insured and to age eighteen if they do not have insurance. CDS also provides dental care to pregnant women.

Children's Dental Services (CDS) will be providing a full range of restorative and preventative care, as well as oral health education to school children in the Brooklyn Center schools. CDS has a history of expertise working with low-income children and those with special needs. Upon formal consent, children are provided with a dental exam, a full range of preventative care, including cleaning, sealants and fluoride, and a full range of restorative care, including fillings, crowns and extractions. For children that are extremely anxious or scared about receiving dental care they can be referred to CDS' headquarters location, in northeast Minneapolis, to receive nitrous gas. CDS also offers general anesthesia appointments for those children with extreme anxiety and extensive treatment needs.

- Dental decay is the most common chronic infectious disease among children.
- 17 percent of children ages 2-4 have already experienced decay, and 78 percent of children by the age of 17 have dental decay.
- More than 51 million school hours are lost each year to the disease.

Care is provided to all children that are eligible for private insurance and medical assistance. CDS also offers a sliding scale discount program for those children that are not eligible for medical assistance. Please contact CDS if you are interested in applying for this program. In the event that the child is not eligible for insurance, CDS works with the families to assist them in applying for medical assistance.

If you are interested in your child receiving dental care in his or her school, please complete the consent form provided by the school. If you have any questions regarding the consent form, or the care provided within the school, please contact Eilidh Reyelts, with Children's Dental Services at: 612-746-1530 ext 211 or ereyelts@childrensdentalservices.org

If you need assistance filling out the form, please contact:
Lucia Mendez (High School age) 763-561-2120 x2104
Marit Kaltved (Elementary age) 763-561-4480 x1122

BROOKLYN CENTER community schools
uniting communities eliminating barriers

Brooklyn Center Schools District 286
Community Schools Health Resource Center
6500 Humboldt Ave. North
Brooklyn Center, MN 55430
Phone: (763) 561-2120

Brooklyn Center

HEALTH RESOURCE CENTER

Consent Form for Dental Exam and Treatment by Children's Dental Services

Note: Please fill out the **consent/authorization form and **medical history** 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:

As a part of Brooklyn Center becoming a Community Schools District, 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, fillings, crowns, extractions and other treatments if needed. If your child requires immediate dental care, you can call CDS at (612) 746-1530 to schedule an appointment (for scheduled appointments you must accompany your child).

If your child has coverage through the Minnesota HealthCare Programs (Medical Assistance or Minnesota Care) or other insurance, and you would like him/her to receive dental care at the on-site dental clinic (provided by CDS), please complete the form below and return it to your child's school.

If your child has no medical and no dental insurance, you may call the Minnesota Department of Human Services at 651-297-3862 to obtain an application form for the Minnesota HealthCare Programs. If you live in Hennepin County, you may also contact Assured Access at 612-348-6141 (for financial screening for sliding-fee-schedule care).

If your child does not have dental coverage and does not qualify for the above mentioned programs, please call CDS at 612-746-1530 to apply for reduced or low-cost dental care.

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

Student's Name (print) _____ Birth Date _____

Student's Social Security Number _____ Gender: Male Female

Parents' Names (print) _____

Parent's E-mail: _____

Address _____

City _____ Zip Code _____ Phone (_____) _____

Child's School _____ Grade _____ Room/Teacher _____

Insurance:

1) Does the patient have insurance through the state? (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**

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.

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** _____

**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.

Children's Dental Services Authorization for Dental Exam and Treatment

I give permission for CDS to provide a dental exam, preventative services, and required restorative care (dental treatment). Specifically I consent to routine dental treatments being performed on my child including examinations, x-rays, cleaning, fluoride, plastic sealants, fillings, crowns, extractions & other treatments if needed. I understand that with any procedure there are associated risks, but that these risks are often outweighed by the benefits of such treatment. Risks of not having treatment done include the following:

1. Toothache, tooth infection, or dental abscess that may cause pain, fever, swelling &/or spread of infection to other parts of the body that can lead to potentially life-threatening complications.
2. Difficulty chewing and/or maintaining good nutrition.
3. Gum inflammation.
4. Development of cyst in gum tissue.
5. Facial swelling.
6. Tooth sensitivity to hot or cold.
7. Ongoing pain, bad breath, unpleasant taste in mouth and difficulty opening mouth.
8. Loss of teeth.

I also understand that while rare, there are certain inherent and potential risks in any treatment plan or procedure, and that such operative risks include but are not limited to the following:

1. Occasional bleeding of the gums that can last up to 12 hours.
2. Swelling of the face or pain or jaw stiffness that can last for several days.
3. Injury to adjacent teeth, tissue, or fillings.
4. Fracture of the jaw and necessity to surgically treat the fracture.
5. Injury to the nerve underlying the lower teeth, resulting in numbness, tingling, pain, or other sensory disturbances to the lip, cheek, chin, gums, teeth, and tongue .
6. Unexpected reaction to the anesthetic.
7. Infection in the tooth socket that can be painful, tender, and swollen if a permanent tooth is extracted.
8. Biting your lip while still numb.

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.

Parent or Guardian's Signature _____ **Date** _____

Witness Signature _____ **Date** _____

MEDICAL HISTORY

Name of patient:_____ Date of birth:_____

1. Has the patient 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 their regular physician: _____

3. Has the patient 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 the patient has had or has at present:

heart failure	chronic cough	persistent diarrhea	kidney trouble	artificial joint
heart disease or attack	tuberculosis (TB)	Hepatitis	Ulcers	arthritis
angina pectoris	Asthma	liver disease	Emphysema	Anemia
high blood pressure	hay fever	yellow jaundice	developmental disability	Stroke
heart murmur	sinus trouble	blood transfusion	AIDS	cortisone medicine
rheumatic fever	allergies or hives	drug addiction	HIV	Glaucoma
congenital heart lesions	Diabetes	Hemophilia	white or blue patches in mouth	sickle cell disease
artificial heart valve	thyroid disease	epilepsy or seizures	enlarged "glands" or lymph nodes	Nervousness
heart pacemaker	x-ray or cobalt treatment	fainting or dizzy spells	cold sores or fever blisters	psychiatric treatment
heart surgery	chemotherapy (cancer, leukemia)	genital herpes	venereal disease(syphilis, gonorrhea, chlamydia)	

5. Does the patient have any disease, condition, or problem not listed? **Y** **N** If yes please list _____

6. Has the patient ever had any operations or surgery? **Y** **N**

If yes, what was the problem? _____ Any complications? (describe) _____

7. Has the patient ever had any excessive bleeding requiring special treatment? **Y** **N**

8. Is the patient taking any medicines, drugs, herbal supplements or vitamins? **Y** **N** If yes, what kind? _____

9. Does the patient have any allergies to drugs or medicines? **Y** **N** If yes, to what and how do they react? _____

10. When was the patient's last dental visit? _____

11. Has the patient ever had any unusual reaction to a dental anesthetic? **Y** **N**

12. Women: Are you (the patient) pregnant now? **Y** **N** If yes, when is the due date? _____

Do you (the patient) think you might be pregnant? **Y** **N**

13. What is the patient's race/ethnicity? _____

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

Parent or Guardian's Signature _____ **Date** _____ Dentist Signature _____ Date _____