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

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, 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 MN Health Care Programs *(Medical Assistance or MNCare)* 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 MN Department of Human Services at 651-297-3862 to obtain an application form for the MN Health Care 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.

Please print:

Student's Name: ______________________ Birth Date: __________

Social Security Number: ______________ Gender: ☐ Male ☐ Female

Parent/Guardian Name(s): ______________ ______________

Parent/Guardian Email Address(s): ______________ ______________

Home Address *(include Apt. #)*: ______________________

City: ______________ Zip Code: __________ Phone: (______) __________

Child's School: ______________ Grade: __________ Room: __________

Insurance:

1. Does the patient have insurance through the state? ☐ Yes ☐ No
   If yes what is member # or PMI#: ______________________
2. Does the patient have insurance through parent/guardian employer or other discount program? ☐ Yes ☐ No
   If yes fill in information below. **Please enclose a front and back copy of insurance or discount card.**

   Name of Dental Insurance/Discount Plan: ______________________

   Policy Holder's Name/Name of Employee: ______________ Birth Date: __________

   Dental Plan Identification Number or Social Security Number: ______________

   Dental Plan Phone: (______) ______________

   Date of Child's Last Dental Visit: ______________ Dentist's Phone: (______) __________

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/Guardian Signature: ______________________ Date: __________

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

Children's Dental Services (CDS) 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, and 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. Tooth ache, tooth infection, or dental abscess that may cause pain, fever, swelling, and/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/Guardian Signature: ____ Date: __________________

Witness Name and Signature: ____ Date: __________________

Patient's Name: ______________________ Birth Date: ____________ Race/Ethnicity: _________

1. Have you seen a physician within the past 2 years? ☐ Yes ☐ No

   If yes, for what problem: ____________________

2. Please give the name, address, and phone number with area code of your regular Health Care Provider (HCP):

   ____

3. Have you been a patient in a hospital within the past 2 years? ☐ Yes ☐ No

   If yes, for what problem: ____________________

4. Check any of the following which you have had or have at present:

☐ AIDS	☐ Emphysema	☐ Kidney Trouble
☐ Allergies or Hives	☐ Enlarged "Glands" or Lymph Nodes	☐ Liver Disease
☐ Anemia	☐ Epilepsy or Seizures	☐ Nervousness
☐ Angina Pectoris	☐ Fainting or Dizzy Spells	☐ Persistent Diarrhea
☐ Arthritis	☐ Genital Herpes	☐ Psychiatric Treatment
☐ Artificial Heart Valve	☐ Glaucoma	☐ Rheumatic Fever
☐ Artificial Joint	☐ Hay Fever	☐ Sickle Cell Disease
☐ Asthma	☐ Heart Disease or Attack	☐ Sinus Trouble
☐ Blood Transfusion	☐ Heart Failure	☐ Stroke
☐ Chemotherapy (Cancer, Leukemia)	☐ Heart Murmur	☐ Thyroid Disease
☐ Chronic Cough	☐ Heart Pacemaker	☐ Tuberculosis (TB)
☐ Cold Sores or Fever Blisters	☐ Heart Surgery	☐ Ulcers
☐ Congenital Heart Lesions	☐ Hemophilia	☐ Venereal Disease (Syphilis, Gonorrhea, Chlamydia)
☐ Cortisone Medicine	☐ Hepatitis	☐ White or Blue Patches in Mouth
☐ Developmental Disability	☐ High Blood Pressure (Hypertension)	☐ X-Ray or Cobalt Treatment
☐ Drug Addiction	☐ HIV	☐ Yellow Jaundice

5. Do you have any disease, condition, or problem not listed? ☐ Yes ☐ No

   If yes, please list: ____________________

6. Have you ever had any operations or surgery? ☐ Yes ☐ No

   If yes, what was the problem: ____________________

   Any complications *(describe)*: ____________________

7. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No

8. Are you taking any medicines, drugs, herbal supplements or vitamins?? ☐ Yes ☐ No

   If yes, please list: ____________________

9. Do you have any <u>allergies</u> to drugs or medicines? ☐ Yes ☐ No

   If yes, to what and how do you react: ____________________

10. When was your last dental visit *(date)*: ____________________

11. Have you ever had any unusual reaction to a dental anesthetic? ☐ Yes ☐ No

12. **Women ONLY:** Are you pregnant now? ☐ Yes ☐ No

    If yes, when is your due date: ____________________

    Do you think you might be pregnant? ☐ Yes ☐ No

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.

Parent/Guardian Signature: ____________________ Date: ____________

DDS Signature: ____________________ Date: ____________