Child's Name: ______________________ Date of Birth: ____________ Grade: _____

DO NOT WRITE BELOW THIS LINE

ALL KIDS SCHOOL-BASED DENTAL PROGRAM DENTAL RECORD

(TO BE COMPLETED BY DENTIST)

PRIOR TREATMENT

Restorations: | Sealants:

TREATMENT NEEDED

Restorative:

Sealants:

S___	S___
S___	S___
S___	S___
S___	S___
S___	S___
S___	S___

(Check off sealants placed today)

ORAL HYGIENE STATUS: ______Good ______Fair ______Poor

PERIODONTAL STATUS: ______Good ______Fair ______Poor

MALOCCLUSION: I II III

(Circle one) ORAL HEALTH ASSESSMENT RATING & SCORE:

3	URGENT Treatment	Abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection or swelling.
2	RESTORATIVE Care:	Amalgams (fillings), composites, crowns, etc.
1	PREVENTIVE Care: (services rendered today)	There is no visual evidence of caries activity or periodontal pathology.

TREATMENT COMPLETED TODAY *(check off)*:

______ EXAM

______ PROPHYLAXIS

______ FLUORIDE TREATMENT VARNISH / GEL

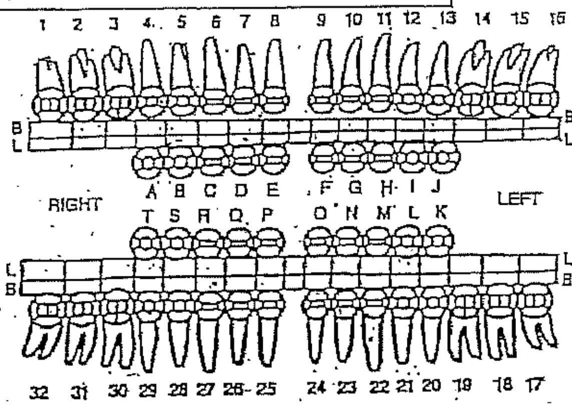
______ SEALANTS

Number of sealants placed today:

Treatment Date:

Dentist's Signature:

Hygienist's Initials:



NOTES:

BLUE=existing restorations; RED=treatment needed (Revised 03/12)

ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

PLEASE PRINT IN INK

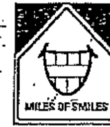
DENTAL EXAM

Services Rendered By:

MUST BE RETURNED TOMORROW (ONLY IF YOU *WANT* THESE SERVICES)

309-382-6404

NAME OF SCHOOL: ______________________________



Miles of Smiles, Ltd.
137-C Radio City Dr.
North Pekin, IL 61554

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 Miles of Smiles, Ltd at school.

Dear Parent or Guardian,

Miles of Smiles, Ltd. 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

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

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: ______________________________

Dental Insurance Company plan or group number: ______________________________

Name of the Employee: ______________________ Phone # of the Employee: ______________________

Address of the Employee *(if different than child's)*: ______________________________

Employee's Date of Birth: ______________________ **Employee's ID *or* SS #:** ______________________

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 minor child named above. I **authorize and consent to** this child receiving the dental **treatment** described, and allow the school nurse/ school representative and dental provider access to child's dental record.

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 directly to Miles of Smiles, Ltd.

SIGNATURE: ______________________________ **DATE:** ____________

IF YOU HAVE A DENTIST, SEEK DENTAL CARE THERE!   DDS INITIALS________ RDH INITIALS________