Children's Dental Services

Children's Dental Services (CDS) provides dental care at school, which may include exams, x-rays, cleanings, fluoride treatment, sealants, fillings, crowns, extractions and other treatments as needed during regular school hours. If you would like your child to receive dental care or if you are able to fill out this form as an adult (18 years or older), please fill out this form and return it to school. ***Please note: Annual permission is required. Please fill out this form every school year to ensure the patient is seen for care. CDS may need to call with questions prior to treatment; please be sure to provide a number to reach you during the school day.***

IF YOU HAVE A REGULAR DENTIST AND YOU DO NOT WISH TO RECEIVE CARE FROM CDS, DO NOT FILL OUT THE FORM.

Patient Name (print) _____ Birth Date _____ ☐Male ☐Female

Parents' Names (print) _____

Address _____ Email:_____

Zip Code _____ Phone (_____) _____ 2nd Phone (_____) _____

Child's School _____ Grade _____ Room _____

HAS THE PATIENT SEEN THE DENTIST IN THE LAST YEAR? ☐YES ☐NO

Approximate date of last dental visit: _____ Date of last x-rays_____

Name of Clinic _____

INSURANCE INFORMATION:

1. Does the patient have insurance through the state? ☐**Yes** ☐**No** **If yes, what is the member ID number (PMI)**_____

2. Does the patient have private insurance through a parent's employer? ☐**Yes** ☐**No** **If yes, fill in information below:**

Name of Dental Insurance _____ Phone # _____

Policy Holder's Name/Name of Employee _____ Date of birth_____

Dental Plan Identification Number or Social Security # _____

CDS offers reduced cost and free care to families who are income eligible.
If your child has no medical and no dental insurance, please call CDS at 612-746-1530 and ask about our sliding scale program.

PATIENT MEDICAL HISTORY:

Is the patient having any dental-related pain or concerns? ☐**Yes** ☐**No**

If yes, please explain: _____

1. Indicate any of the following that apply to the patient:

ADHD/ADD	☐Yes ☐No	Cold sores or fever blisters	☐Yes ☐No	Hemophilia	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	Congenital heart disease	☐Yes ☐No	Hepatitis/liver disease	☐Yes ☐No
Anemia	☐Yes ☐No	Dental anxiety	☐Yes ☐No	High blood pressure	☐Yes ☐No
Artificial heart valve	☐Yes ☐No	Depression/psychiatric	☐Yes ☐No	Kidney disease	☐Yes ☐No
Artificial joint	☐Yes ☐No	Developmental disability	☐Yes ☐No	Radiation/chemotherapy	☐Yes ☐No
Asthma	☐Yes ☐No	Diabetes	☐Yes ☐No	Rheumatic fever	☐Yes ☐No
Autism spectrum	☐Yes ☐No	Drug addiction	☐Yes ☐No	Thyroid disease	☐Yes ☐No
Blood transfusion	☐Yes ☐No	Epilepsy or seizures	☐Yes ☐No	Tuberculosis (TB)	☐Yes ☐No
Chemical dependency	☐Yes ☐No	Heart murmur	☐Yes ☐No		

Please explain any boxes marked yes: _____

2. Does the patient have any disease, condition, or problem not listed? ☐**Yes** ☐**No**
If yes, please list _____

3. Does the patient have any allergies to food, drugs or medicines? ☐**Yes** ☐**No**
If yes, to what and how do you/ your child react? _____

4. Is the patient taking any medicines, drugs, herbal supplements or vitamins? ☐**Yes** ☐**No**
If yes, list all medications _____

5. Has the patient ever had any unusual reaction to a dental anesthetic? ☐**Yes** ☐**No**

6. Has the patient ever had any excessive bleeding requiring special treatment? ☐**Yes** ☐**No**

7. Has the patient seen a physician within the past 2 years? ☐**Yes** ☐**No**
If yes, for what reason? _____

8. Has the patient been hospitalized within the past 2 years? ☐**Yes** ☐**No**
If yes, for what reason? _____

9. Has the patient ever had any operations or surgery? ☐**Yes** ☐**No**
If yes, what was the reason? _____
Were there any complications? (describe)_____

10. Is the patient pregnant now or possibly pregnant? ☐**Yes** ☐**No** ☐**N/A**
If yes, when is your due date? _____

Children's Dental Services Authorization for Dental Exam and Treatment: I give permission for CDS to provide a dental exam, preventive services, and required restorative care (dental treatment). Specifically I consent to routine dental treatments being performed on my child, including examinations, x-rays, cleanings, fluoride, and plastic sealants. I understand that CDS staff may be in contact with me to obtain additional informed consent to provide restorative procedures such as 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.

I give permission for CDS to bill my insurance for any services provided to the individual listed for care and I understand that I am responsible for any amount not covered by the insurance. I give my permission for CDS to share the patient's oral health information with the school, to provide the most comprehensive care possible. This consent form is valid for one year from the date signed unless revoked in writing to CDS. If I had any further questions about the risks and benefits of treatment or alternate treatment options I have contacted a provider 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. The medical history provided is accurate to the best of my knowledge. If my medical history changes I will inform CDS.

_____ _____

Parent/Guardian (or patients 18 years of age or older) Signature **Date**

**Please note: If you or your child is seen by one of CDS' hygienists this does not take the place of an exam; we recommend a full examination with the dentist within 6 months if he/she has not already done so.