Children's Dental Services

Children's Dental Services (CDS) provides dental care at school, which may include exams, x-rays, cleanings, fluoride treatment, sealants, **silver diamine fluoride (SDF)**, 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. 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 DO NOT want your child to be seen, please DO NOT fill out this form

Step 1: Patient Information

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

Parents' Names (print) _____

Address _____ Zip Code: _____

Phone (____) _____ 2nd Phone (____) _____ Race/Ethnicity _____

Child's School _____ Grade _____ Teacher _____

Step 2: Dental Information

IS THE PATIENT HAVING ANY DENTAL-RELATED PAIN OR CONCERNS? ☐ **Yes** ☐ **No**

If yes, please explain: _____

HAS THE PATIENT SEEN THE DENTIST IN THE LAST 6 MONTHS? ☐ **Yes** ☐ **No**

IF YES: Approximate date of last dental visit: _____ Name of Clinic _____

Step 3: Insurance Information

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

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

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

Name of Dental Insurance _____ Name of Employer _____

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

Dental Plan Identification Number or Social Security # _____

Step 4: Medical History

1. **Indicate YES to all that applies to the patient, and indicate NO to all that DOES NOT apply to the patient.**

PLEASE MARK EVERY BOX.

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

Please explain any boxes marked yes: _____

CONTINUE TO NEXT PAGE →

PLEASE MARK EVERY BOX

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, SILVER, 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? _____

Step 5: Review Authorization Information

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. **For the treatment of minor cavities, I consent to the use of silver diamine fluoride (SDF). I am aware that SDF will turn the decayed area of the tooth gray or black in color, I am also aware there is a risk that the use of SDF may not stop the decay, and that the tooth may still require a filling.** 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 lip while still numb.

Children's Dental Services carefully follows Centers for Disease Control's health and safety guidelines relating to COVID-19.

Step 6: **Sign and Date Consent Form**

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 permission for CDS to share the patient's oral health information with the school and the school permission to share information necessary for the provision of care to the patient, to provide the most comprehensive care possible. I also give permission for the school to share student information with CDS (including class schedules and data). 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.