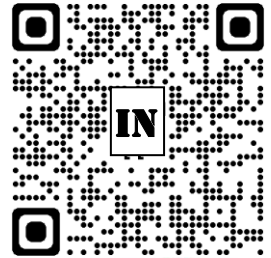


DENTAL CONSENT FORM



School _____ Grade _____
County _____ Teacher _____

Child's Name _____ ☐ Male ☐ Female
Child's Birth Date ____ / ____ / ____
Cell Phone _____ e-mail _____
Address, City, State, Zip _____



☐ **Medicaid / Hoosier Healthwise** (12-digit ID# required)

SEND A PIC of Medical Card to MyCard@dentalsafaricompany.com

Medical Card/Hoosier Healthwise RECIPIENT ID# _____ (12-digit # on back of Card)

☐ **Private Insurance**

SEND A PIC of Insurance Card to MyCard@dentalsafaricompany.com

DENTAL Insurance Company Name _____ Employer _____
Primary Name _____ Phone _____
Primary Address _____
Primary: Birth Date ____ / ____ / ____ Primary Soc. Sec. #: _____
Insurance Company Phone _____
Member ID#: _____ Group #: _____

☐ **Uninsured** – Reduced Fee Services. \$75 pay via PayPal on website: www.DentalSafariCompany.com

☐ **Provisional (Need-Based) Services – No Charge** – qualify for Free/Reduced Lunch AND No Insurance

HEALTH HISTORY – Check ALL that apply:

☐ AD/HD ☐ Blood Disorders ☐ Heart ☐ Speech Disorder ☐ Allergies ☐ Asthma ☐ Cerebral Palsy ☐ Growth Issues
☐ Pregnancy ☐ Tobacco/Drugs ☐ Autism ☐ Chronic Sinusitis ☐ Hearing ☐ Other: _____

Have you been told your child requires antibiotics before dental procedures ☐ Yes ☐ No

Is child allergic to any medication? _____

Is child taking any medication at this time? _____

CHECK ALL THE WAYS we can communicate with you: ☐ Call ☐ Text ☐ e-mail

List any Individuals / Relatives that we can communicate with regarding child's dental healthcare:

☐ By checking, I **ALSO CONSENT** to restorative care which may include: appropriate fillings, crowns, pulpotomies, baby teeth extractions (with or without space maintainers)

Comments / Concerns:

Parents/Guardian: DENTAL SAFARI COMPANY, a fully licensed, professional corporation, will be at your child's school. By signing this consent form, my child receives an exam by a licensed dentist, possibly x-rays, cleaning, Fluoride, sealants and SDF (topical cavity treatment) up to two times during the school year.
I give permission to treat child and understand my **HIPAA rights** as well as **Ambient Listening** may be used for exam purposes only –view at www.DentalSafariCompany.com.

PRINT NAME _____ relation _____ SIGNATURE _____ date _____