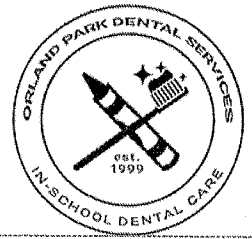


# ORLAND PARK DENTAL SERVICES CONSENT FORM



PLEASE PRINT IN INK | MUST BE RETURNED TOMORROW (ONLY IF YOU WANT THESE SERVICES)

View or download our HIPPA privacy policy: [www.opdsdental.com/hippa-en](http://www.opdsdental.com/hippa-en)

Name of school: \_\_\_\_\_ County: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

**Provide the following information only if you want these dental services**

Dear Parent or Guardian,

OPDS, Ltd. and The Illinois Department of Public Aid 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 INFORMATION REQUESTED BELOW AND SIGN IN THE AREA INDICATED.**

Your child's legal name: \_\_\_\_\_ Home phone: \_\_\_\_\_ Gender: M / F

Street address: \_\_\_\_\_ City/Zip: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If yes, include your child's recipient ID number: \_\_\_\_\_ (9 digit ID number on back of Medi-Plan card)  
**\*\*Medicaid/All Kids will be billed\*\***

Is your child enrolled in the 'Medicaid/All Kids' Program: Yes / No Does your child qualify for free or reduced meals: Yes / No

Is your child covered by private dental insurance: Yes / No Name of dental insurance company: \_\_\_\_\_

Dental insurance co. will be billed Dental insurance company address: \_\_\_\_\_

Member's (employee) ID or SS #: \_\_\_\_\_ Dental insurance plan or group number: \_\_\_\_\_

Member's name: \_\_\_\_\_ Member's birthdate: \_\_\_\_\_

Member's address (if different than child's): \_\_\_\_\_ Employer: \_\_\_\_\_

**Has your child had any history of, or conditions related to, any of the following? (Circle all that apply)**

Anemia: Yes / No	Latex allergy: Yes / No	Diabetes: Yes / No	Is your child taking any prescription and/or over the counter medications at this time? Yes / No If yes, please list:
Asthma: Yes / No	Seizures: Yes / No	Allergies:	Does your child have any known heart condition? Yes / No Describe:
Other:			Does your child have any artificial joints: Yes / No If yes, when and what joint:

Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatments? 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 the child's dental record. This will also give permission for the Illinois Department of Public Health to provide Quality Assurance Audits by evaluation of your child's sealants that were placed at the school. Upon determination, this permission will also allow for the sealants to be replaced by the provider if indicated. 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 to OPDS, Ltd. This also gives permission for OPDS to come back this school year and provide a possible prophylaxis and fluoride treatment for your child.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

----- DO NOT WRITE BELOW THIS LINE - TO BE COMPLETED BY DENTIST -----

Prior Restoration    Prior Sealants

Decay                      Sealants Placed Today

Score \_\_\_\_\_

Sealants Present     Yes     No  
Prior to exam -- 1<sup>st</sup> molars only

Caries Experience     Yes     No

Untreated Caries     Yes     No

Oral Hygiene Status     Good     Fair     Poor

Periodontal Status     Good     Fair     Poor

**Oral Health Assessment Rating**

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

Treatment Date: \_\_\_\_\_

Dentist/Hygienist Signature: \_\_\_\_\_  
(Reviewed Name / D.O.B)