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

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
Dental insurance co. will be billed

Member's (employee) ID or SS #:_____

Member's name:_____

Member's address *(if different than child's)*:_____

Name of dental insurance company:_____

Dental insurance company address:_____

Dental insurance plan or group number:_____

Member's birthdate:_____

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 prophy 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
		Sealants Present ☐ Yes ☐ No Prior to exam – 1st molars only		
		Caries Experience ☐ Yes ☐ No		
		Untreated Caries ☐ Yes ☐ No		
		Oral Hygiene Status ☐ Good ☐ Fair ☐ Poor		
		Periodontal Status ☐ Good ☐ Fair ☐ Poor		

Score_____

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)

Revised: 02/20