Dental Treatment Consent Form

Dear Parent/Guardian:

Dental Access Carolina offers complete general dental services on-site at your child's school. Our mobile clinics are equipped with everything necessary to provide preventive and restorative dental treatment. **If your child is enrolled in SC Medicaid, there is no cost to you!** We also accept private insurance from all major insurance carriers.

A team of professionals, **led by an experienced doctor**, will visit the school on a regular basis throughout the school year to provide dental services, including exams, x-rays, cleanings, fillings and more. You will receive a detailed report of any treatment your child receives after each visit.

☐ **Yes –** I want my child to receive dental care from Dental Access Carolina

- I am the legal guardian of my child
- I **understand and consent** to the information on this form

Sign this form, fill out front and back, and return to your child's teacher or school nurse

☐ **No** – I do not want my child to receive dental care from Dental Access Carolina

Child's Full Name:_____

Write your child's name above, then return this form to your child's teacher or school nurse

Signature of Parent/Guardian_____ Date _____

Printed Name of Person Completing Form_____

If you checked "YES", please fill out the blue box below AND the medical history on the back. SIGN the form and return to school!

Child's Full Name _____ Birthdate (mm/dd/yy)_____ / _____ / _____

School_____ Grade_____ Teacher _____

SC Medicaid # _____ (Include **ALL 10 Digits**)

OR

Insurance Company _____ Ins Co Phone _____

Subscriber name _____ Subscriber ID _____

Subscriber Social Security # _____ Subscriber Birthdate (mm/dd/yy) _____ / _____/_____

Employer_____

Group Name _____ Group # _____

Patient's Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child

Parent or Guardian Name_____ Phone _____

Home Address _____ City_____ Zip _____

Email Address _____ Consent to Contact via Email? □ Yes □ No

Emergency Contact _____ Phone _____

PLEASE COMPLETE PATIENT'S MEDICAL HISTORY ON THE BACK OF THIS PAGE.

*I understand and **authorize** Dental Access Carolina, LLC ("Provider") to provide dental care and treatment for the child listed above, and I certify that I am authorized to give such consent. I understand that the dental treatments which may be provided could generally include dental exams, x-rays, cleanings, dental sealants, fluoride treatment, fillings, extractions, pulpotomies and root canal treatments. I understand and have been advised that, as with any dental treatment, these procedures may entail some risk of complications, and that a listof such potential complications can be found at www.dentalaccesscarolina.com/FAQ. I **authorize** & direct Provider to bill & collect payment from Medicaid, insurance, or any other payer. I hereby authorize release of any information that will assist in treatment or in processing of claims for services rendered. If I have private dental insurance, I understand that I am responsible for any balance deemed patient responsibility/non-payable/ non-covered by insurance. I understand that photographs may be taken for educational or documentation purposes and give consent. I have provided an updated medical history form to Provider (see reverse page). Provider is **authorized** to rely on said medical history form until notified of any change in writing. This signed consent **authorizes** treatment for my child at my child's initial and future dental visits. I may withdraw this consent at any time prior to treatment in writing.*

Dental Access Carolina, LLC and its employees and affiliates are not agents or employees of the school district.
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