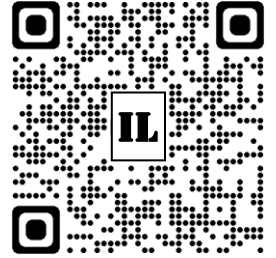


DENTAL CONSENT FORM



School _____ Grade _____
County _____ Teacher _____

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



Medicaid / All Kids (9-digit ID# required)

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

Medical Card KidCare / All Kids Card RECIPIENT ID# _____
(9-digit # on back of Card)

Private Insurance

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

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

Yes No **I want 6-month recall** – exam, prophylaxis, Fluoride, sealants, SDF (topical cavity treatment)

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? List _____

Is child taking ANY medication at this time? _____

Parents/Guardian: DENTAL SAFARI COMPANY, a fully licensed, professional corporation, will be at your child's school. By signing this consent form, child receives an exam by a licensed dentist or a (PHDH) Public Health Dental Hygienist, cleaning, Fluoride, sealants and SDF (topical cavity treatment).

I give permission to treat child and understand my HIPAA rights—view at www.DentalSafariCompany.com

PRINT NAME _____ relation _____ SIGNATURE _____ date _____