Mercer County Dental Program Permission Form

Mercer County School Or Sherrard School Grade: _____

Teacher: _____

Dear Parent or Guardian,
Mercer County Health Department has arranged for dental services for all 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 a mobile dental unit. **In order for your child to receive these services you must provide ALL the information requested below and sign in the area indicated.**

Your Child's Name: _____ Age: _____ Gender: M F

Birth Date: _____/_____/_____ Home/Cell Phone: _____

Mailing Address: _____ City/Zip: _____

Number of family members: _____ Income per year (optional):_____

Does your child have a Dental Home? YES NO Dentist Office: _____
Last dental cleaning: _____

Does your child have a Medicaid card YES NO if no, please fill out dental insurance

If yes, include your child's recipient ID number: ___ ___ ___ ___ ___ ___ ___ ___ ___
9 digit # on card

Dental Insurance: Please do not put your medical insurance dental ins only.

Name of Dental Insurance: _____ Dental Insurance Phone: _____
Subscriber Name: _____ DOB: _____Group: _____
ID: _____or SS#: _____

Has your child had any history of, or conditions related to, any of the following:

___ Anemia	___ Chicken Pox	___ Hearing	___ Liver	___ Sickle Cell
___ Arthritis	___ Chronic Sinusitis	___ Heart	___ Measles	___ Thyroid
___ Asthma	___ Diabetes	___ Hepatitis	___ Mononucleosis	___ Tobacco/drug use
___ Bladder	___ Ear Aches	___ HIV/AIDS	___ Mumps	___ Tuberculosis
___ Bones/ Joints	___ Epilepsy	___ Immunization	___ Pregnancy (teens)	___ Venereal disease
___ Cancer	___ Fainting	___ Kidney	___ Rheumatic Fever	___ Other _____
___ Cerebral Palsy	___ Growth Problems	___ Latex Allergy	___ Seizures	

Is your child taking any over the counter medications at this time? YES NO

If yes, please list: _____
_____
_____

Over →

Dentist's Initials _____

Services to be completed at Toothmobile
Please mark what you would like the dentist to do.
<u>If it is blank your child will have everything completed that is needed.</u>

Dental Exam: _____ $29.40
Cleaning: _____ $43.05
Fluoride: _____ $27.30
Dental Sealant: _____ $37.80 x each tooth (Could do up to 4 teeth)

***In signing this form, this will also give permission for IDPH Quality Assurance Audits, for up to one year, to be performed and providers to return to our school to recheck your child's dental work.**

Privacy Practice Acknowledgment

- I am aware that MCHD has a HIPAA (Health Insurance Portability and Accountability Act) Notice of Privacy Practices.
- I may request a copy at any time by contacting MCHD.
- In signing this form, you give permission to treat your child and also verify that you have read the additional form regarding HIPAA.

Agreement to Pay for Services

- I authorize MCHD to release my medical information necessary to Medicaid/Insurance to process claims and further authorize payment of dental benefits payable directly to MCHD Community Health System.
- If you need help covering the cost of the dental services, please contact MCHD.

Important: Parent/guardian signature required

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 marked above (dental exam, prophylaxis, fluoride treatment and sealants) and that I understand the above payment information.
I allow the school nurse/school representative, dental provider and IDPH access to the child's dental record.

Signature: _____ Date: _____

Please call 1-309-582-3759 for any questions.
Stephanie would be happy to answer them.