Children's Dental Services

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# Authorization for Dental Exam and Treatment at School

Children's Dental Services (CDS) provides dental care at school, including exams, x-rays, cleanings, fluoride, sealants, fillings, crowns, primary tooth extraction, silver diamine fluoride (SDF), and others, as needed, during regular school hours. **If you would like your child to receive dental care, please fill out this form and return it to the school nurse. This consent will be valid for 1 year from the date signed.**

Only complete this form if you would like your child to be seen exclusively by dental providers from CDS.

## Child Information

**Name:** _____ **Date of Birth:** ____/____/____
First Middle Last Name(s) mm dd yyyy

**Sex:** ☐Male ☐Female **Pronouns:** _____ **Primary/Home Language:** _____

**School:** _____ **Grade:** _____

## Guardian Information

**Name:** _____ **Date of Birth:** ____/____/____
First Middle Last Name(s) mm dd yyyy

**Address:** _____
Number Street Apt/Unit City State Zip Code

**Phone Numbers:** (_____) _____ - _____ (_____) _____ - _____

**E-mail:** _____@_____

## Patient Medical History

1. **Has your child been seen at another dentist in the last 6 months?** ☐No ☐Yes, where? _____
   Approximate date of last visit: ____/____/____ & x-rays: ____/____/____
   mm dd yyyy mm dd yyyy
2. **Is your child having any dental-related pain or concerns?** ☐No ☐Yes, explain: _____
3. **Indicate if any of the following apply to the patient by marking each box:**

| | | | | | |
|---|---|---|---|---|---|
| Attention Deficit Hyperactivity Disorder (ADHD) | ☐Yes ☐No | Chemical Dependency | ☐Yes ☐No | Hemophilia | ☐Yes ☐No |
| Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) | ☐Yes ☐No | Cold Sores/Blisters | ☐Yes ☐No | Hepatitis/Liver Disease | ☐Yes ☐No |
| Anemia | ☐Yes ☐No | Congenital Heart Disease | ☐Yes ☐No | High Blood Pressure | ☐Yes ☐No |
| Artificial Heart Valve | ☐Yes ☐No | Dental Anxiety | ☐Yes ☐No | Kidney Disease | ☐Yes ☐No |
| Artificial Joint | ☐Yes ☐No | Developmental Disability | ☐Yes ☐No | Radiation/Chemotherapy | ☐Yes ☐No |
| Arthritis | ☐Yes ☐No | Depression / Anxiety | ☐Yes ☐No | Rheumatic Fever | ☐Yes ☐No |
| Asthma / Wheezing | ☐Yes ☐No | Diabetes | ☐Yes ☐No | Thyroid Disease | ☐Yes ☐No |
| Autism Spectrum Disorder (ASD) | ☐Yes ☐No | Acid Reflux (GERD) | ☐Yes ☐No | Tuberculosis** | ☐Yes ☐No |
| Blood Transfusion | ☐Yes ☐No | Epilepsy / Seizures | ☐Yes ☐No | Skin Issues/Eczema/Rash | ☐Yes ☐No |
| Cancer | ☐Yes ☐No | Heart Murmur | ☐Yes ☐No | Sexually Transmitted Infection (STI) | ☐Yes ☐No |
| Current Pregnancy ☐No ☐Yes, due date: ____/____/____ | | Other: _____ | | | |

****If you responded yes to tuberculosis, have they had a recent positive test result and/or are they currently in treatment? Has a physician indicated that the tuberculosis is dormant or not currently active?** _____

4. **Do they have any allergies?** ☐No allergies ☐Silver ☐Latex ☐Dye ☐Food: _____
   ☐Drugs: _____ ☐Other: _____ **Explain:** _____
5. **Are they taking medications, drugs, vitamins, or herbal supplements?** ☐No ☐Yes, list which: _____
   _____
6. **Have they had an unusual reaction to dental anesthetic?** ☐No ☐Yes, explain what the reaction was: _____
7. **Have they had any excessive bleeding that needed special treatment?** ☐No ☐Yes

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8. **Have they seen a physician or been hospitalized within the past two years?** ☐No ☐Physician ☐Hospitalization

Reason: _____

9. **Have they had any surgery or operation?** ☐No ☐Yes, explain the reason: _____

_____. If you had any complications, which? _____

## Dental Insurance Information (Response Required)

- **Our services are billed directly to your child's dental insurance, so complete insurance information is needed to see them.** Please, answer the following questions fully:

☐Minnesota State Covered Insurance (MA) **PMI or Medicaid ID #:** 0 ☐☐☐☐☐☐☐☐☐☐

☐Private Insurance. Fill out the following information for the **subscriber**:

Insurance Company Name: _____ Customer Service Number: (_____) _____ - _____

Employer: _____ Employee Name: _____
First MI Last Name(s)

Date of Birth: ____/____/_____ Member ID #: _____ Group #: _____
mm dd yyyy

- If your child does not have insurance, CDS can help you apply for MN state insurance or offer a reduced cost to families who are income-eligible. If no insurance, indicate your interest: ☐ Help applying to state insurance ☐ Discount with CDS

## Acknowledgment

I give permission for CDS to provide a dental exam, preventive services and required restorative dental treatment. Specifically, I consent to routine dental treatments being performed on my child, including examinations, x-rays, cleanings, fluoride, silver diamine fluoride (SDF), and plastic sealants. I understand that CDS staff will contact me for additional informed consent to provide restorative procedures, such as fillings, crowns, extractions of primary teeth, dental anesthetic, and other treatments as needed, and it is my responsibility to provide correct contact information.

I understand that there are risks associated with any procedure but that these risks are often outweighed by the benefits of such treatment. Risks of **not** having treatment done include the following:

- Toothache, infection, and/or abscess causing pain, fever, and swelling, with the possibility of infection spreading to other parts of the body and leading to potentially life-threatening complications
- Difficulty chewing and/or maintaining good nutrition
- Gum inflammation
- Development of cyst in gum tissue
- Facial swelling
- Tooth sensitivity to hot or cold
- Ongoing pain, bad breath, unpleasant taste in mouth, and difficulty opening mouth
- Loss of teeth

I also understand that, while rare, there are certain inherent and potential risks in any treatment plan or procedure, and that such operative risks include but are not limited to the following:

- Occasional bleeding of the gums that can last up to 12 hours
- Swelling of the face, pain, or jaw stiffness that can last for several days
- Injury to adjacent teeth, tissue or fillings
- Fracture of the jaw and the necessity to surgically treat the fracture
- Unexpected reaction to dental anesthetic
- Injury to the nerve underlying the lower teeth, resulting in numbness, tingling, pain, or other sensory disturbances to the lips, cheek, chin, gums, teeth and tongue
- Infection of the tooth socket of an extracted permanent tooth, resulting in pain, tenderness, or swelling
- Biting of the lip while anesthetic effect is still present

By signing this consent form, I give permission for CDS to bill my insurance for any services provided to the individual listed for care, and I understand that I am responsible for any amount not covered by the insurance. To provide the most comprehensive care possible, I give permission for CDS to share the patient's oral health information with the school. **This consent is valid for 1 year from the date signed unless revoked in writing to CDS.** If I had any further questions about the risks and benefits of treatment or alternate treatment options, I contacted a provider at CDS to ask such questions, and they were answered adequately. I have had adequate time to make the decision to give consent freely. The medical history provided is accurate to the best of my knowledge, and if this changes, I will inform CDS.

_____ _____

**Signature of Parent/Legal Guardian (or 18+ year-old student)** **Date (Valid for one year)**