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 / Hoosier Healthwise** (12-digit ID# required)

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

Medical Card / Hoosier Healthwise RECIPIENT ID# _ _ _ _ _ _ _ _ _ _ _ _

(*12-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, prophy, Fluoride, sealants, SDF (topical cavity treatment)

HEALTH HISTORY – Check ALL that apply:

❑ AD/HD ❑ Blood Disorders ❑ Heart ❑ Speech Disoder ❑ Allergies ❑ Asthma ❑ Cerebral Palsy ❑ Growth Issues
❑ Pregnacy ❑ 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