Smile Illinois...the mobile dentists are coming to shine your smile!

Please return this form to your child's teacher in the next 2 days

- ☺ **Signature required for treatment.**
- ☺ Treatment is limited to exams, cleanings, fluoride, sealants and referral when necessary*. All professional services provided by Illinois licensed dentists & hygienists; managed by Elliot P. Schlang, D.D.S P.C.
- ☺ Insurance such as *Medicaid* and *All Kids* cover your child **100%**.

General and Health Information **PLEASE PRINT CLEARLY IN INK**

School or Program Name: ______________________ County: ____________

Teacher: ______________________ Grade: ________ Room #: ____________

Child's Legal Name: ____________ (First) ____________ (Middle) ____________ (Last)

Child's Date of Birth: ______ (Month) ______ (Day) ______ (Year) Child's Sex: M F (Circle one) Last Dental Visit: ____________

Your child's Social Security number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Parent/Guardian Name (signing below): ______________________ Cell or Phone: ( ) (area code) ____________

Address: ______________________ City/Zip: ____________

Relationship to child: ____________ E-MAIL: ____________

Circle when child attends: M T W TH F AM / PM Full Day

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

☐ Asthma ☐ Blood disorder ☐ Diabetes ☐ Hepatitis ☐ Heart murmur (not requiring pre-medication) ☐ Shunts or artificial joints
☐ Hemophilia ☐ Latex allergy ☐ Allergies ☐ Heart valve replacement ☐ Heart murmur (requiring pre-medication) ☐ HIV/AIDS ☐ Other (describe)

✱ **IMPORTANT:** List all medications, health history & other problems below. *Attach another page if more space is needed*

____

Medicaid/All Kids

☺ We accept *Medicaid, All Kids* and most private insurance.

Child's 9-digit Medicaid Recipient ID Number: ☐☐☐☐☐☐☐☐☐

Name of Private Dental Insurance Company (other than Medicaid): ____________ Ins. Phone: ____________

Group number: ____________ Employer name: ____________ Co. Phone: ____________

Name of person under whom child is covered: ____________ **BIRTH DATE of Insured Adult:** ____________

Social Security number of insured adult: ____________ Contract / ID number: ____________

Secondary insurance information: Insurance Name: ________ Policy Holder: ________ Date of Birth: ________
ID Number: ________ Employer Phone: ________ Insurance Co. Phone #: ________

No Medicaid or Dental Insurance **Only Check ONE Box**

☐ I am able to pay the full fee of **$73** for a dental cleaning, screening, fluoride and sealants per visit. Please make check or money order payable to **Smile Illinois** and staple to this form.

☐ I need to pay **$67** for a subsidized service because I am unable to pay full fee. It will cover dental cleaning, screening, fluoride & sealants. Please make check or money order payable to **Smile Illinois** and staple to this form.

☐ Check here if you need financial aid for insurance co-pays/deductibles if any. Most insurance covers prevention 100%.

☐ Check here if you have NO dental insurance **AND** you need full financial assistance for cleaning, screening, fluoride & sealants. We will mail you a grant application.

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 described, and allow the school nurse/school representatives, the local public health department(s), and/or a dentist of my choosing to obtain the child's dental record. I authorize and direct Elliot P. Schlang, D.D.S P.C. to bill on my behalf or the child's behalf; and collect payment from any insurance or other third party payer that covers the services provided to this child. I have had an opportunity to ask any questions about treatment my child may receive. I acknowledge receiving a notice of privacy practices today before signing. I understand that this child will receive the results of the dental exam on an Oral Health Report Card given to the child on the day of treatment. If I do not receive it or need another copy I will contact the toll free number listed below.*

X Sign Here ______________________ (Parent/Guardian) Date: ____________

If the child has a dentist, you may wish to continue dental services with that provider. To avoid dental service or benefit duplication, please inform your dentist which services were performed at school (see oral health report card, provided after school dental visit, which will indicate services provided).

* Sealants applied at dentist's discretion. In cases where additional dental care is required for restorative and/or other dental needs, the parent/guardian must follow up with a dentist of their own choosing.

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