Children's Dental Services carefully follows the Centers for Disease Control's health and safety guidelines for COVID-19.

Children's Dental Services

Not JUST for children

Children's Dental Services (CDS) provides dental care at school and in communities for children AND adults. Services, which may include exams, x-rays, cleanings, fluoride treatment, sealants, **silver diamine fluoride (SDF)**, fillings, crowns, extractions and other treatments, are provided during regular school hours during the school year. If you would like for you or your child to receive dental care or if you are and teenager 18 years or older, please fill out this form and return it to the school or community organization from which you received it. **Please note: Annual permission is required. CDS may need to call with questions prior to treatment; please be sure to provide a number to reach you during the school day.**

If you DO NOT want your child to be seen, please DO NOT fill out this form.

Step 1: Patient Information

❑ Male ❑ Female

Patient Name (print) _____ Birth Date _____ Race/Ethnicity _____

Parent/Guardian Name if applicable (print) _____ Phone _____

Address_____ Zip Code:_____

If Child: School _____Grade_____ Teacher _____

Step 2: Dental Information

Is the patient having dental related concerns? ❑ **Yes** ❑ **No** If yes, please explain:_____

Has the patient seen the dentist in the last 6 months? ❑ **Yes** ❑ **No** If YES: Approximate date of last dental visit: _____

Name of Dental Clinic: _____

Step 3: Insurance Information

CDS accepts all forms of insurance. Your insurance must be **ACTIVE** at the time of your exam. If the patient has no dental insurance and is under 26, they may qualify for our sliding fee scale. **Please call CDS at 612-746-1530 and ask about our sliding scale program BEFORE the patient is seen. YOU ARE RESPONSIBLE FOR ANY PART OF THE BILL NOT COVERED BY YOUR INSURANCE PLAN. Ask about a payment plan if you feel you may not be able to pay in full.**

A. Does the patient have insurance through the state? ❑ **Yes** ❑ **No** **If yes, what is the member ID number (PMI)**_____

B. Does the patient have private insurance through a parent's employer? ❑ **Yes** ❑ **No** **If yes, fill in information below:**

Name of Dental Insurance_____Name of Employer_____

Policy Holder's Name/Name of Employee_____Date of birth_____

Dental Plan Identification Number or Social Security # _____

Step 4: Review Authorization Information

Children's Dental Services Authorization for Dental Exam and Treatment: I give permission for CDS to provide a dental exam, preventive services, and required restorative care (dental treatment). Specifically I consent to routine dental treatments, including examinations, x-rays, clean- ings, fluoride, and plastic sealants. **For the treatment of minor cavities, I consent to the use of silver diamine fluoride (SDF). I am aware that SDF will turn the decayed area of the tooth gray or black in color, I am also aware there is a risk that the use of SDF may not stop the decay, and that the tooth may still require a filling.**

I understand that CDS staff may be in contact with me to obtain additional informed consent to provide restorative procedures such as fillings, crowns, extractions and other treatments if needed. I understand that with any procedure there are associated risks, but that these risks are often outweighed by the benefits of such treatment.

Risks of not having treatment done include the following:

• Tooth ache, tooth infection, or dental abscess that may cause pain, fever, swelling, and/or spread of infection to other parts of the body that can lead to potentially life-threatening complications.	• Development of cyst in gum tissue. • Facial swelling • Tooth sensitivity to hot or cold complications • Ongoing pain, bad breath, unpleasant taste in mouth
• Difficulty chewing and/or maintaining good nutrition	• Loss of teeth
• Gum inflammation.	

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

• Occasional bleeding of the gums that can last up to 12 hours • Swelling of the face or pain or jaw stiffness that can last for several days	• Injury to the nerve underlying the lower teeth, resulting in numbness, tingling, pain, or other sensory disturbances to the lip, cheek, chin, gums, teeth, and tongue.
	• Unexpected reaction to the anesthetic.
• Injury to adjacent teeth, tissue, or fillings.	• Biting lip while still numb.
• Fracture of the jaw and necessity to surgically treat the fracture.	• Infection in the tooth socket that can be painful, tender, and swollen if a permanent tooth is extracted.

Step 5: Patient Medical History

Circle YES to all that applies to the patient and circle NO to all that DOES NOT apply to the patient. Please MARK EVERY condition.

ADHD/ADD	**Yes**	**No**	Congenital Heart Disease	**Yes**	**No**	Hemophilia	**Yes**	**No**
Anemia	**Yes**	**No**	Dental Anxiety	**Yes**	**No**	Hepatitis/Liver Disease	**Yes**	**No**
Artificial Heart Valve	**Yes**	**No**	Depression	**Yes**	**No**	High Blood Pressure	**Yes**	**No**
Artificial Joint	**Yes**	**No**	Developmental Disability	**Yes**	**No**	Kidney Disease	**Yes**	**No**
Asthma	**Yes**	**No**	Diabetes	**Yes**	**No**	Radiation/chemotherapy	**Yes**	**No**
Blood Transfusion	**Yes**	**No**	Drug Addiction	**Yes**	**No**	Rheumatic Fever	**Yes**	**No**
Chemical Dependency	**Yes**	**No**	Heart Murmur	**Yes**	**No**	Thyroid disease	**Yes**	**No**
Cold sores or fever blisters	**Yes**	**No**				Tuberculosis	**Yes**	**No**

Please explain anything circled yes: _____

1. Does the patient have any disease, condition or problem not listed? Yes No
   If yes, please list. _____
2. Does the patient have any allergies to foo, drugs, SILVER or any medicines? Yes No
   If yes, how does the patient react? _____
3. Is the patient taking any medicines, drugs, herbal supplements or vitamins? Yes No
   If yes, list all medications. _____
4. Has the patient ever had an unusual reaction to a dental anesthetic? Yes No
5. Has the patient ever had any excessive bleeding requiring special treatment? Yes No
6. Has the patient seen a physician within the past two years? Yes No
   If yes, for what reason? _____
7. Has the patient been hospitalized in the past two years? Yes No
   If yes, for what reason? _____
   Were there any complications? If so, please describe: _____
8. Has the patient ever had any operations or surgeries? Yes No
   If yes, for what reason? _____
   Were there any complications? If so, please describe: _____
9. Is the patient pregnant now, or possibly pregnant? Yes No N/A

Step 6: Sign and Date 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.** I give permission for CDS to share the patient's oral health information with the school and the school permission to share information necessary for the provision of care to the patient, to provide the most comprehensive care possible. I also give permission for the school to share student information with CDS (including class schedules and data). **This consent form is valid for one 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 have contacted a provider at CDS to ask such questions and they have been 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. If my medical history changes I will inform CDS.

**Please note: If you or your child is seen by one of CDS' hygienists this does not take the place of an exam; we recommend a full examinationwith the dentist within 6 months if he/she has not already done so.

_____ _____

Signature of Parent or Guardian Date