

*****DENTAL SCREENING... PLEASE RETURN AS SOON AS POSSIBLE*****

PLEASE PRINT IN INK!!!

NAME OF SCHOOL: _____
 TEACHER: _____ GRADE: _____
 COUNTY: _____

If you are not interested in this program, please print your child's name and put "NO" on this form.

Dear Parent or Guardian,

OPDS, Ltd. and The Illinois Department of Public Aid have arranged for dental services for eligible 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 portable equipment. 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 _____ Birth date ____/____/____ Home Phone () ____ - ____ Gender: Male / Female

Please Print

Address: _____ City: _____ Zip: _____

DOES YOUR CHILD HAVE ANY MEDICAL HISTORY THAT MAY COMPLICATE DENTAL TREATMENT?

Heart murmur _____; Latex allergy _____; Blood disorder _____; Other _____

DENTIST'S INITIALS

Reviewed Health History

DOES YOUR CHILD **QUALIFY FOR FREE AND REDUCED MEALS** Yes No

of family members _____ Income per year (optional) _____

IS YOUR CHILD ENROLLED IN THE "ALL KIDS" PROGRAM (PUBLIC AID/MEDICAID/KID CARE)? Yes No

If YES, Include your child's RECIPIENT ID NUMBER

9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD

IS YOUR CHILD COVERED BY **PRIVATE** DENTAL INSURANCE Yes No

ETHNICITY: Hispanic _____ Non Hispanic _____ RACE: White _____ African American _____
 American Indian/Alaska native _____ Asian/Pacific Islander _____ Other _____ Unknown _____

DENTIST'S INITIALS

Reviewed Signature

****Signature:** _____ **Date:** _____

PARENT OR GUARDIAN MUST SIGN TO PARTICIPATE!!!!!!

****In signing this form, you are giving permission to treat your child and also verifies that you have read the back of this form regarding HIPAA.**

****This will also give permission for IDPH, QA Audits and providers to return to your school and re-check your child's sealants.**

DO NOT WRITE BELOW THIS LINE

(rev. 03/11)

TO BE COMPLETED BY DENTIST

Prior Restorations – Prior Sealants

_____	Sealants Present	_____ YES	_____ NO (Prior to exam – 1 st molars only)
_____	Caries Experience	_____ YES	_____ NO
_____	Untreated Caries	_____ YES	_____ NO
_____	Oral Hygiene Status	_____ GOOD	_____ FAIR _____ POOR
_____	Periodontal Status	_____ GOOD	_____ FAIR _____ POOR

CURRENT DENTAL STATUS OF PATIENT:

TREATMENT NEEDED

DECAY

SEALANTS
Placed Today

SCORE

ORAL HEALTH ASSESSMENT RATING

- | | |
|-------|---|
| _____ | 1. Preventive Care (services rendered today) – There is no visual evidence of caries activity or periodontal pathology. |
| _____ | 2. Restorative Care – Amalgams, composites, crowns, etc. |
| _____ | 3. Urgent Treatment – Abscess, nerve exposure advanced disease state, signs or symptoms that include pain, infection or swelling. |

Dentist/Hygienist Signature _____ / _____
 (Reviewed Name/D.O.B)

Treatment Date: _____ Dentist's Signature: _____