## UNIVERSAL SMILES... "giving all kids a smile"



## **DENTAL CONSENT FORM**

Universal Smiles has partnered with your child's school to provide on-site dental services. The dental team, headed by a licensed dentist will provide the following services, as indicated: dental exam/screening, dental cleaning, fluoride treatment and sealants (if needed). Sealants are a protective plastic coating placed on the chewing surfaces of the permanent back teeth that do not appear to be decayed. NO needles or anesthetic is ever used. This program does not offer restorative services (fillings) or removal of teeth. You will be contacted if your child requires any additional services. We encourage you to participate, especially if your child does not have a regular dentist. Let's enhance the oral health of your child!

SS# or ID# of Person Insured: Group#:  Employer's Name:	Female	Male F	Date of Birth:	[	Student's Name:	
Address:  City Zip code  MEDICAID ID #:	rade	Grade			ame:	School Nar
MEDICAID ID #:		one #	Pho		Guardian Name:	Parent/Gu
MEDICAID ID #:						Address: _
Ins. Phone#  Name of Private Dental Insurance:  Name of Private Dental Insurance:  Name of the Insured:  SS# or ID# of Person Insured:  Employer's Name:  MEDICAL INFORMATION: Has your child had any history of, or any conditions listed below? YES / NO (IF YES CIRCLE CONDITION) Diabetes Seizures Currently has a heart murmur Asthma Anemia Cancel Hepatitis Rheumatic Fever Heart Disease Blood Disease Hearing Epilepsy Thyroi  Is your child taking any medication? If YES, please list:  Does your child have any allergies? If Yes, please list:  Any other medical related conditions? If yes please list:  Has your child ever suffered injuries to the mouth, head or teeth? YES / NO  As the parent or guardian of the above named child or ward, I consent for my child to participate in the dental progra Quality assurance exams. I authorize the provider dentist to use my child's or ward's insurance, Medicaid or ALL KIDS nur		Zip code	City			
Name of Private Dental Insurance:		SS#		PLAN NAME:	AID ID #:	MEDICAID
Name of the Insured:		ving:	supply the following	vate Dental Insurance please sup	child is covered by P	If your chi
Employer's Name:    MEDICAL INFORMATION:		Ins. Phone#		ance:	f Private Dental Insu	Name of F
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UNIVERSAL SMILES 1583 Huntington Drive, Calumet City, IL 60409 I 708-818-8090 I universalsmiles@aol.com

www.universalsmiles.biz