



PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name:			Last		First		Middle		Birth Date: (Month/Day/Year) / /		
Address:		Street			City			ZIP Code		Telephone:	
Name of School:						Grade Level:			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Parent or Guardian:						Address (of parent/guardian):					

To be completed by dentist:

Oral Health Status (check all that apply)

Yes No **Dental Sealants Present**

Yes No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

Yes No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

Yes No **Soft Tissue Pathology**

Yes No **Malocclusion**

Treatment Needs (check all that apply)

Urgent Treatment — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

Restorative Care — amalgams, composites, crowns, etc.

Preventive Care — sealants, fluoride treatment, prophylaxis

Other — periodontal, orthodontic

Please note _____

Signature of Dentist _____

Date of Exam _____

Address _____
Street City ZIP Code

Telephone _____



Consent and Policy Disclosures

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. This is also to acknowledge that you understand our offices policies for appointment cancellations and payment agreements.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain those changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (708)485-8200 or at 3739 Grand Boulevard, Brookfield , IL 60513

Notice of Cancellation Policy: We do require at least 24 hour notice for any appointment cancellations. Patients that repeatedly don't show or cancel appointments the same day will be charged a fee of \$30.00.

Notice of Payment Agreement: By signing this form, I agree to be the responsible party for payment of all services rendered on my behalf or for my dependents. I agree that I shall be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18%APR) and any expenses such as collection fees or attorney fees if engaged for the purpose of collections may be added to my account.

Treatment Authorization: I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patient's dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the office listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____