



Miles of Smiles, Ltd.

ATTENTION PARENTS!!!!!!

Miles of Smiles, Ltd. is providing preventive dental services (exam, cleaning, fluoride varnish, and sealants if needed) at your school to eligible children in all grades.

This satisfies the Illinois State mandated dental examination requirement for school children (Kindergarten, 2nd, and 6th).

Please sign your child up today to receive this wonderful service (up to a \$475 value).

PLEASE PRINT IN INK

DENTAL EXAM

Services Rendered By:

MUST BE RETURNED TOMORROW

(up to a \$475 value)

NAME OF SCHOOL: _____



Miles of Smiles, Ltd.

TEACHER: _____ GRADE: _____

137-F Radio City Dr.

COUNTY: _____

North Pekin, IL 61554

Dear Parent or Guardian,

309-382-6404

Miles of Smiles, Ltd. and The Illinois Department of Healthcare and Family Services 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 CHILDS NAME: _____ BIRTH DATE: ____/____/____

ADDRESS: _____ GENDER: M / F

CITY/ZIP: _____ HOME PHONE: _____

DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS: YES / NO

IS YOUR CHILD ENROLLED IN THE 'Medicaid/All Kids' PROGRAM: YES / NO

IF YES, INCLUDE YOUR CHILD'S RECIPIENT ID NUMBER: _____ (9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD)
Medicaid/All Kids will be billed

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES / NO (The dental insurance company will be billed)

If YES, please fill out ALL the insurance information below: (if incomplete, only grades K, 2nd, & 6th may be eligible for an exam)

Name of Dental Insurance Company: _____

Dental Insurance Company Address: _____

Dental Insurance Company plan or group number: _____

Name of the Insured: _____ Phone # of the Insured: _____

Address of the Insured: _____

Insured Date of Birth: _____ Insured ID or SS #: _____

Employer: _____ Employer Phone #: _____

Employer Address: _____

Has your child had any history of, or conditions related to, any of the following: (Please circle)							
Anemia:	YES / NO	Chronic Sinusitis:	YES / NO	Growth problems:	YES / NO	Seizures:	YES / NO
Asthma:	YES / NO	Diabetes:	YES / NO	Hearing:	YES / NO	Thyroid:	YES / NO
Bleeding disorders:	YES / NO	Ear aches:	YES / NO	Heart:	YES / NO	Tobacco / drug use:	YES / NO
Cancer:	YES / NO	Epilepsy:	YES / NO	Latex allergy**:	YES / NO	Allergies:	
Cerebral Palsy:	YES / NO	Fainting:	YES / NO	Pregnancy (teens):	YES / NO	Other:	
Is your child taking any prescription and/or over the counter medications at this time?					YES / NO		
If yes, please list:							

What type of water does your child drink? ___ City water ___ Well water ___ Bottled water ___ Filtered water

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 representative and dental provider access to child's dental record.

To the extent permitted by law, I consent to the use and disclosure of the minor child's protected health information to carry out payment activities in connection with this claim. I hereby authorize and direct payment of the dental benefits directly to Miles of Smiles, Ltd.

SIGNATURE: _____

DATE: _____

DDS INITIALS _____ / RDH INITIALS _____

Child's Name: _____ Date of Birth: _____

****DO NOT WRITE ON THIS PAGE****

ALL KIDS SCHOOL-BASED DENTAL PROGRAM DENTAL RECORD

(TO BE COMPLETED BY DENTIST)

PRIOR TREATMENT

Restorations:	Sealants:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ORAL HYGIENE STATUS: _____ Good _____ Fair _____ Poor
 PERIODONTAL STATUS: _____ Good _____ Fair _____ Poor
 MALOCCLUSION: I II III

(Circle one) ORAL HEALTH ASSESSMENT RATING & SCORE:

3	<u>URGENT</u> Treatment: Abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection or swelling.
2	<u>RESTORATIVE</u> Care: Amalgams (fillings), composites, crowns, etc.
1	<u>PREVENTIVE</u> Care: There is no visual evidence of caries activity or periodontal pathology. (services rendered today)

TREATMENT NEEDED

Restorative:	Sealants:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Check off sealants placed today)

TREATMENT COMPLETED TODAY:

_____	S	S
_____	S	S
_____	S	S
_____	S	S

NOTES:



Treatment Date: _____ Dentist's Signature: _____

Number of sealants placed today: _____ Hygienist: _____