Children’s Dental Services (CDS) is a non-profit dental provider dedicated to providing care to children from birth to age twenty-six and pregnant women. CDS offers dental care to all school children within your child’s school.

Upon completion of the attached consent, children are provided with dental care during school hours by Children’s Dental Services.

CDS accepts all forms of public and private insurance. No child is denied treatment due to an inability to pay. We assist families in applying for medical assistance and offer a sliding scale discount program for families ineligible for medical assistance. Please contact us if you would like assistance in applying for medical assistance or the sliding scale program.

Visit our website at:

www.childrensdentalservices.org

If you have any questions regarding the consent form or care provided at your child’s school, please contact Alyssa Beaulieu, Operations Manager, Children’s Dental Services at:

612-843-0202 or abeaulieu@childrensdentalservices.org
Children’s Dental Services (CDS) provides dental care at school, which may include exams, x-rays, cleanings, fluoride treatment, sealants, fillings, crowns, extractions and other treatments as needed during regular school hours. If you would like your child to receive dental care or if you are able to fill out this form as an adult (18 years or older), please fill out this form and return it to school. 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**

<table>
<thead>
<tr>
<th>Patient Name (print)</th>
<th>Birth Date</th>
<th>□ Male □ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guardians’ Names (print)</td>
<td>Zip Code:</td>
<td></td>
</tr>
<tr>
<td>Phone ( )</td>
<td>2nd Phone ( )</td>
<td>Race/Ethnicity</td>
</tr>
<tr>
<td>Child’s School</td>
<td>Grade</td>
<td>Teacher</td>
</tr>
</tbody>
</table>

**Step 2: Dental Information**

<table>
<thead>
<tr>
<th>IS THE PATIENT HAVING ANY DENTAL-RELATED PAIN OR CONCERN? □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, please explain:</td>
</tr>
<tr>
<td>HAS THE PATIENT SEEN THE DENTIST IN THE LAST 6 MONTHS? □ Yes □ No</td>
</tr>
<tr>
<td>IF YES: Approximate date of last dental visit: Name of Clinic</td>
</tr>
</tbody>
</table>

**Step 3: Insurance Information**

CDS offers reduced cost to families who are income eligible. If your child has no dental insurance, please call CDS at 612-746-1530 and ask about our sliding scale program.

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: Medical History**

1. Indicate YES to all that applies to the patient, and indicate NO to all that DOES NOT apply to the patient. **PLEASE MARK EVERY BOX.**

| ADHD/ADD | □ Yes □ No | Cold sores or fever blisters | □ Yes □ No | Hemophilia | □ Yes □ No |
| AIDS/HIV | □ Yes □ No | Congenital heart disease | □ Yes □ No | Hepatitis/liver disease | □ Yes □ No |
| Anemia | □ Yes □ No | Dental anxiety | □ Yes □ No | High blood pressure | □ Yes □ No |
| Artificial heart valve | □ Yes □ No | Depression/psychiatric | □ Yes □ No | Kidney disease | □ Yes □ No |
| Artificial joint | □ Yes □ No | Developmental disability | □ Yes □ No | Radiation/chemotherapy | □ Yes □ No |
| Asthma | □ Yes □ No | Diabetes | □ Yes □ No | Rheumatic fever | □ Yes □ No |
| Autism spectrum | □ Yes □ No | Drug addiction | □ Yes □ No | Thyroid disease | □ Yes □ No |
| Blood transfusion | □ Yes □ No | Epilepsy or seizures | □ Yes □ No | Tuberculosis (TB) | □ Yes □ No |
| Chemical dependency | □ Yes □ No | Heart murmur | □ Yes □ No | Silver Allergy | □ Yes □ No |

Please explain any boxes marked yes: 

CONTINUE TO NEXT PAGE
2. Does the patient have any disease, condition, or problem not listed? □ Yes □ No
   If yes, please list ________________________________

3. Does the patient have any allergies to food, drugs or medicines? □ Yes □ No
   If yes, to what and how do you/your child react? ________________________________

4. Is the patient taking any medicines, drugs, herbal supplements or vitamins? □ Yes □ No
   If yes, list all medications ________________________________

5. Has the patient ever had any unusual reaction to a dental anesthetic? □ Yes □ No

6. Has the patient ever had any excessive bleeding requiring special treatment? □ Yes □ No

7. Has the patient seen a physician within the past 2 years? □ Yes □ No
   If yes, for what reason? ________________________________

8. Has the patient been hospitalized within the past 2 years? □ Yes □ No
   If yes, for what reason? ________________________________

9. Has the patient ever had any operations or surgery? □ Yes □ No
   If yes, what was the reason? ________________________________

10. Were there any complications? (describe) ________________________________

11. Is the patient pregnant now or possibly pregnant? □ Yes □ No □ N/A
   If yes, when is your due date? ________________________________

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Step 5: 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 being performed on my child, including examinations, x-rays, cleanings, fluoride, and plastic sealants. 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:

1. 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.
2. Difficulty chewing and/or maintaining good nutrition.
3. Gum inflammation.
4. Development of cyst in gum tissue.
5. Facial swelling.
6. Tooth sensitivity to hot or cold.
7. Ongoing pain, bad breath, unpleasant taste in mouth and difficulty opening mouth.
8. Loss of teeth.

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

1. Occasional bleeding of the gums that can last up to 12 hours.
2. Swelling of the face or pain or jaw stiffness that can last for several days.
3. Injury to adjacent teeth, tissue, or fillings.
4. Fracture of the jaw and necessity to surgically treat the fracture.
5. 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.
6. Unexpected reaction to the anesthetic.
7. Infection in the tooth socket that can be painful, tender, and swollen if a permanent tooth is extracted.
8. Biting lip while still numb.

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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 my permission for CDS to share the patient’s oral health information with the school, to provide the most comprehensive care possible. 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.

**Parent/Guardian (or patients 18 years of age or older) Signature ________________________________ Date ____________

**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 examination with the dentist within 6 months if he/she has not already done so.