

Smile Illinois  
...the mobile dentists



**THE DENTIST IS COMING TO YOUR SCHOOL!**

**Our school has joined with Smile Illinois  
to offer in-school dental care at  
NO COST\* to you.**

**Taking care of your child's teeth is important to keep them healthy.**

**EASY & CONVENIENT** - A state licensed dentist will regularly check your child's mouth & teeth, as well as provide a cleaning, fluoride treatment and apply sealants, as needed. A dental report card will be sent home with your child. Includes initial dental care & follow-up visits. **SIGN AND RETURN TO YOUR SCHOOL TODAY!**

**PLEASE COMPLETE**

Child's Legal Name		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	City	State	Zip
School	Teacher		Grade
Parent/Guardian Name		Phone (      )	
Email		Alt Phone (      )	

**IMPORTANT HEALTH QUESTION**

Does your child have any past or present medical or dental conditions or disabilities? This may include heart issues, breathing problems, brain/seizure disorders, allergies (including drug allergies), diabetes, bleeding problems, communicable diseases or immune disorders etc. If Yes, explain below (attach additional pages as needed). IF NO, LEAVE BLANK.

List current medications \_\_\_\_\_ List any dental concerns \_\_\_\_\_

**IF CHILD HAS MEDICAID/ALL KIDS**

Enter Child's Medicaid  
Recipient ID Number HERE: →

\*Medicaid & All Kids cover 100% of treatment

Circle one of the following:

Aetna, BCBS, County Care, Family Health Network, Health Alliance Connect, Harmony, Humana, IlliniCare, Meridian, Molina, NextLevel

**OR** Child's Social Security # (if available)

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**IF CHILD HAS PRIVATE DENTAL INSURANCE**

Ins. Company name (other than Medicaid) \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Group # \_\_\_\_\_ Employer name \_\_\_\_\_ Co. phone \_\_\_\_\_

Name of Insured Adult \_\_\_\_\_ BIRTH DATE of Insured Adult \_\_\_\_\_

Member ID/Policy # \_\_\_\_\_ Social Security # of insured adult \_\_\_\_\_

**IF CHILD HAS NO DENTAL INSURANCE**

- My child does not have dental insurance.
- I will pay the reduced fee of **\$70.00** for a dental cleaning, screening, fluoride & sealants per visit. (We will send you a donated care application. Available only once per school year for preventive care only.) If paying for services, staple check or money order to this form & make payable to: Smile Illinois.

**If your child sees a dentist regularly, and you want to continue care with that dentist, you should do so.**

**READ & SIGN BELOW**

I request that the dentist perform preventive dental care on my child which includes exam, cleaning, fluoride, and sealants as needed. This permission includes future dental visits. This also gives permission for IDPH quality assurance audits to be performed & providers to return to my child's school to recheck my child's sealants. I have read the IMPORTANT HEALTH QUESTION above and will report any significant changes in my child's health to 855-481-8639. I have read the IMPORTANT NOTICE AND CONSENT ON THE BACK OF THIS FORM and understand and agree to its terms.

**SIGN & DATE HERE** →

DATE \_\_\_\_\_

QUESTIONS: 1-855-481-8639 FAX: 1-888-330-4331 Visit us at: [mobiiledentists.com](http://mobiiledentists.com)

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For your privacy, please fold & secure.

**ESPAÑOL AL REVERSO**

