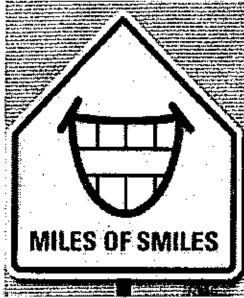

Miles of Smiles, Ltd.

ATTENTION PARENTS!!!!!!

IT IS MORE IMPORTANT THAN EVER TO SIGN YOUR CHILD UP FOR MILES OF SMILES, LTD!

COVID-19 has been a barrier to getting children the dental care they need.

Miles of Smiles, Ltd. has resumed the school-based dental program and assures you that infection control will continue to be our top priority.

The "**CDC** supports states to put into action **school sealant programs** that reduce oral disease and improve oral health." *CDC.gov/oral health/dental sealant programs*

- Miles of Smiles, Ltd. is providing preventive dental services at your school to eligible children in **all grades.**
- Services may include exam, cleaning, fluoride varnish, and sealants if needed.
- This also satisfies the dental requirement mandated by the State of Illinois for school children: (Kindergarten, 2nd, 6th, and 9th).
- Please sign up your child today to receive this wonderful service.
- There is ***no cost*** to the family or school.
- After the services are performed, the following entities will be billed where applicable: IL Medicaid program, public/private grants, or private dental insurance.
- Miles of Smiles, Ltd. will accept any reimbursement as the final payment (even if the claim is denied). The families and the schools are never billed for any copayments, deductibles, or balances.

There is never any cost to the school or to the families.
***If you see a dentist regularly,
please continue for routine exams and x-rays!***

All Kids online application & forms:
https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/application.aspx
All Kids Hotline: 1-866-ALL-KIDS (1-866-255-5437)

2424 N 8th St. * Pekin, IL 61554-1547 * Office: 309-382-6404 * Fax: 309-382-6405

ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

Rev 06/17

PLEASE PRINT IN INK

DENTAL EXAM

★ ***MUST BE RETURNED TOMORROW*** **(ONLY IF YOU WANT THESE SERVICES)** ★

Services Rendered By:
Miles of Smiles, Ltd.
2424 N 8th St
Pekin, IL 61554-1547
309-382-6404

NAME OF SCHOOL:______________________

TEACHER:______________________ GRADE: ______

COUNTY:______________________

DO YOU HAVE A DENTIST? YES / NO **DENTIST'S NAME:** **EXAM DATE:**

PROVIDE THE FOLLOWING INFORMATION ONLY IF YOU WANT THESE DENTAL SERVICES to be rendered by Miles of Smiles, Ltd at school.

Dear Parent or Guardian,

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 CHILD'S LEGAL 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

MCO COMPANY NAME (if not listed): ______________________

MCO COMPANY NAME (circle one): Aetna, BCBS, Cigna, CommunityCare, CountyCare, Family Health Network, Harmony, Humana, IlliniCare, Meridian, Molina

IF YES, INCLUDE YOUR **CHILD'S RECIPIENT ID NUMBER:** ⟶ ___ ___ ___ ___ ___ ___ ___ ___ ___

Medicaid/All Kids will be billed (9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD)

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES / NO (if incomplete, only grades K, 2nd, & 6th may be eligible for an exam)

If YES, please fill out **ALL** the insurance information below: ***(DENTAL INSURANCE COMPANY WILL BE BILLED)***

Name of Dental Insurance Company:______________________

Dental Insurance Company Address:______________________

Member's (employee) ID or SS #:______________________ Dental Insurance plan or **group number**:______________________

Member's name:______________________ **Member**'s Birth Date:______________________

Member's Address *(if different than child's)*:______________________

Member's Phone Number *(if different than child's)*:______________________ Employer:______________________

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 Disease:	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:

Does you child have any known heart condition? YES / NO DESCRIBE:

Does your child have any artificial joints: YES / NO IF YES, WHEN & WHAT JOINT:

Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? YES / NO

IF YES, WHAT:

IMPORTANT: PARENT/GUARDIAN SIGNATURE REQUIRED ***(ONLY IF YOU WANT THESE SERVICES)***

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.

This will also give permission for the Illinois Department of Public Health to provide Quality Assurance Audits by evaluation of your child's sealants that were placed at the school. Upon determination, this permission will also allow for the sealants to be replaced by the provider if indicated.

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: **PRINT NAME:** **DATE:**

IF YOU HAVE A DENTIST, SEEK DENTAL CARE THERE! DDS INITIALS__________ RDH INITIALS__________