Revised 10-2023

AURORA CHILDREN'S DENTAL SERVICE APPLICATION

Instructions: Please complete all information below. All information will be kept strictly confidential. Once completed, please return to School Nurse. If your application is approved, you will be notified by the school nurse and contacted by Aurora Children's Dental Service to schedule an appointment.

Student Information:

Name: ______________________________ DOB: ________________ Age: ________

School: ____ Grade: _______

Home Address: ____

Parent/Guardian 1:

Name: ______________________________ Relationship to Student: ______________

Place of Employment: ________________________ Work Phone Number: ______________

Gross Monthly Income: ______________

Parent/Guardian 2:

Name: ______________________________ Relationship to Student: ______________

Place of Employment: ________________________ Work Phone Number: ______________

Gross Monthly Income: ______________

Additional Questions:

1. Do you have dental insurance for your family? Yes _____ No _____
2. Are you receiving assistance from the Department of Public Aid? Yes _____ No _____
3. Do you have a general dentist? Yes _____ No _____ If Yes, Dentist's Name: ________________

I request the help of Aurora Children's Dental Service in securing the needed dental care for my child. I understand that an adult must be present at all dental visits. I understand that it is my responsibility to contact the dentist's office at least 24 hours in advance if my child's appointment needs to be rescheduled. In addition, I understand that my child will be dropped from the program if there are unnecessary cancellations or broken appointments.

Signature of Parent/Guardian: ________________________________ Date: ____________

**** Section below must be completed by SCHOOL NURSE ****

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Reason for Referral: ____

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Date of Referral: ______________

This child requires Urgent Treatment: Yes _____ No _____

If Yes, Please Describe: ____

Does the child have any medical condition(s)/Diagnosis that would affect their ability to receive standard dental care:

____

Signature of School Nurse: ____________________________ Phone Number: ______________