Student: _____ ID#: _____ School: _____

Birthdate: _____ Gender: _____ Grade: _____ Room: _____

ROCKFORD PUBLIC SCHOOLS

Health Services
Dental Program
501 7th Street, 7th Floor
Rockford, IL 61104
Phone (815) 966-3166

TO RECEIVE RESTORATIVE DENTAL VIA THE RPS205 DENTAL PROGRAM

If you would like Rockford Public Schools to arrange for restorative dental care, simply **complete and sign the enclosed forms**; then return them to your child's school. For those patients with Medicaid or All-Kids, dental work will be provided at no cost. For those with private insurance or no insurance, co-pays and deductibles may apply, but *you will be contacted and notified of this before any work begins*.

- Medical and Dental History Form: This form lists any details the dentist may need to know before performing the work your child needs.
- Consent and Registration Form: Allows RPS205 to arrange for and perform the services that your child needs.
- Consent to Release form: Allows us to transport your child to and from the dentist's office.

All three pages must be signed for this consent to be valid. After you complete and return these forms to your child's school nurse, we will arrange the necessary care. Students will be transported for care to any one of the following: Crusader Community Health, Dr. Oates Dental, or Park City Dental. A note will be sent home with your child a couple of days before their appointment date to notify you of the appointment day, time, and location. A school district representative will accompany them through the process to ensure their safety and well-being. You are welcome to meet your child at the dental office on the day the appointment is to take place.

If you have any questions, please call us at (815)966-3166 during regular office hours. We look forward to helping your child be as successful a student as possible.

Sincerely,

Rockford Public Schools Health Services

Restorative dental services through the RPS205 dental program are provided by the following:

Park City DENTAL
555 N. Court St., Suite 100
Rockford, IL 61103
(815)708-6556

Dr. Oates dental
3957 N. Mulford Rd., Suite 1
Rockford, IL 61114
(815)637-6400

Crusader Community Health
1100 Broadway, Rockford, IL 61104
1200 W. State St., Rockford, IL 61102
6115 N. 2nd St., Loves Park, IL 61111
1002 N. Pierpont Av., Rockford, IL 61101
(815)490-1374/(815)490-1428

09/2018

HIPAA NOTICE OF PRIVACY PRACTICES: Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights. You have the right to: Get a copy of your paper or electronic medical record, Correct your paper or electronic medical record, Request confidential communication, Ask us to limit the information we share, Get a list of those with whom we've shared your information, Get a copy of this privacy notice, Choose someone to act for you, File a complaint if you believe your privacy rights have been violated.

Your Choices. You have some choices in the way that we use and share information as we: Tell family and friends about your condition Provide disaster relief Include you in a hospital directory Provide mental health care Market our services and sell your information Raise funds

Our Uses and Disclosures. We may use and share your information as we:

-Treat you Run our organization
-Bill for your services
-Help with public health and safety issues
-Do research
-Comply with the law
-Respond to organ and tissue donation requests Work with a medical examiner or funeral director
-Address workers' compensation, law enforcement, and other government requests
-Respond to lawsuits and legal actions

Your Rights When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

-Get an electronic or paper copy of your medical record - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

-Ask us to correct your medical record- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. Ask us to limit what we use or share You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Choose someone to act for you If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices. For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission: Marketing purposes. Sale of your information. Most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures. How do we typically use or share your health information? We typically use or share your health information in the following ways.

-Treat you. We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

-Run our organization**.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

-Bill for your services**.** We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services. How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues. We can share health information about you for certain situations such as: Preventing disease Helping with product recalls Reporting adverse reactions to medications Reporting suspected abuse, neglect, or domestic violence Preventing or reducing a serious threat to anyone's health or safety

Do research. We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you: For workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

PROVIDERS (to contact your Privacy Official)

Orland Park Dental Services: 809 W. Detweiller Dr., Suite 805A, Peoria, IL 61615. (309)692-1320. Fax (309)692-1355. & Crusader Community Health: 1100 Broadway, Rockford, IL 61104. (815)490-1600. Fax (815)963-4843 (SCHOOLS: Auburn, Conklin, East, Ellis, Kennedy, Lewis Lemon, Lincoln, McIntosh, Nelson, Rolling Green, Spring Creek, Washington, West, Wilson Aspire)

Onsite Dental Services/Park City Dental: 555 N. Court St., Suite 100, Rockford, IL 61103. (815)708-6556. Fax (815)708-6477. (SCHOOLS: Barbour, Beyer, Dennis, Flinn, Froberg, Hillman, Jefferson, King, Kishwaukee, Lathrop, Nashold, RESA, Riverdahl, Roosevelt, Summerdale, Whitehead)

Dr. Oates Dental: 3957 N. Mulford Rd., Rockford, IL 61114. (815)637-6400. Fax (815)637-6477. (SCHOOLS: Bloom, Brookview, Carlson, Cherry Valley, Eisenhower, Fairview, Gregory, Guilford, Haskell, Johnson, Marshall E.S., Marshall M.S., Montessori, Welsh, West View)

Medical and Dental History Form

Patient Name_____ Date of Birth_____ Student ID_____
Medical Doctor_____ Address_____ Phone_____
Date of Last Medical Visit_____ Reason for medical visit _____

1. Is patient currently under the care of a medical doctor? _____Yes _____No Reason _____
2. Is patient taking any medications? _____Yes _____No

If yes, list drugs:

a.	Reason
b.	Reason
c.	Reason

3. Is patient allergic to penicillin/amoxicillin? _____Yes _____No
4. Is patient allergic to other medications? _____Yes _____No
   If yes, please state name of drug/reaction: _____
5. FEMALES: Is there any possibility patient is pregnant? _____Yes _____No If yes, how many months? _____
   Taking birth control pills _____ Yes _____No
6. Does patient have or ever had any of the following?

	Yes	No	Comments
Heart disease, heart murmur, or heart surgery			
Bleeding or blood clotting problems/diseases			
Diabetes (blood sugar problems)			
Sickle cell anemia or trait			
Thyroid problems			
Convulsions/seizures or fainting spells			
Tuberculosis			
Hepatitis or other liver problems			
Kidney problems			
Asthma or wheezing			
Cancer, leukemia, other tumor			
Birth defects, or genetic defects			
HIV and/or AIDS			
Drug and/or alcohol dependency			
Received steroid treatment			
Developmental or Intellectual disability			
Cigarette or smokeless tobacco use			
Other:			

7. Does the patient have a history of, or is currently suffering from a medical condition not mentioned above?
_____Yes _____No If yes, what is the medical condition? _____
8. Has the patient's doctor recommended any special precautions for dental treatment?
____Yes ____No If yes, what precautions? _____
9. Indicate if patient has any of these: ____Blindness ____Hearing Problems ____Speech Problems

PATIENT'S DENTAL HISTORY

1. Reason you are seeking dental care for patient: _____
2. Has patient ever been to a dentist before? ____Yes ____No If yes, name of dentist_____
3. Has patient ever had any of the following?

	Yes	No	Comments
Injuries to the mouth or teeth?			
Toothache and/or abscesses?			

4. Does patient have any of the following habits?

	Yes	No	Comments
Finger, thumb or pacifier sucking?			
Mouth breathing?			

5. Is your child taking fluoride supplements in any form? ___Yes ___No
6. Do you think patient receives proper daily dental care? ___Yes ___No
7. What type of water does patient drink? ___Community tap water ___Well water ___Bottled water
8. Other dental information we should know? _____

I certify that I have read and understood the above questions. To the best of my knowledge the above information is correct. I will not hold the treating dentist(s) or any member of the dental staff responsible for any errors or omissions I may have made in the completion of this form. I understand that it is my responsibility to inform my patient's dentist when there is a change in my patient's medical condition, or when there is a change in the responses to any of the above questions.

Person completing this form: _____ Signature: _____

Relationship to patient: _____ Date: _____ Time: _____

Phone number where you can be reached during the day: _____

Are you legally responsible for this patient? _____
(If NO, we may need a written or oral consent from the person/institution legally responsible for this child.)

Student: _____ ID#: _____ School: _____

Birthdate: _____ Gender: _____ Grade: _____ Room: _____

Consent and Registration Form

This form is to obtain your consent for dental treatment or oral surgery procedures. Please read this form very carefully and ask us about anything that you do not understand. Your child's dentist or the dental staff will be pleased to explain it. Thank you.

Patient Name: _____ Guardian Name: _____

Address: _____ [ ] CHECK IF SAME Address: _____

_____ _____

City: _____, IL ZIP: _____ City_____, IL ZIP_____

Email_____

Phone number(s) where you can be reached during the day:

Cell _____ Home _____ Work _____

Medicaid: 9 or 11-Digit Medicaid Recipient ID Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

If you are insured through a private insurance carrier please complete this section:

Private Dental Insurance Company: _____ Group Number: _____

Company Phone Number: _____ Policy Number: _____

Address to send claims (on card): _____

Name of person under whom patient is covered: _____ Employer: _____

Birth Date of Insured Adult: _____ Social Security Number: _____ Employer Phone: _____

(If possible attach photocopy of front and back of card)

I hereby authorize payment of dental benefits for the services described. I give my permission to the doctor to submit insurance benefit claim forms in my name and on behalf of myself, my spouse and/ or my minor patient. I realize that I may be responsible for and agree to pay any charges not covered by my insurance. This includes unmet deductibles, non-covered services, etc.*

*Patients covered through Medicaid will not have a copay for covered procedures.

A. Below is a list of dental procedures that may be performed on your patient. A treatment plan will be made for your child and sent home after their initial appointment. Since you may not be present at dental appointments, it is important that you read this material carefully and call the appropriate provider if you have any questions.

1. **Diagnostic Procedures:** Examination, radiographs (x-rays) of the teeth & jaws, consultation, photographs, dental casts.
2. **Teeth Cleaning:** Removal of soft and hard deposits on teeth, and teeth polishing with special toothpaste.
3. **Fluoride Treatment:** A solution of fluoride is placed on teeth after cleaning. Fluoride hardens the surface of teeth and helps them resist tooth decay.
4. **Dental Sealants:** Plastic sealants are applied to the grooves of the chewing surface of erupted permanent molar teeth to help resist tooth decay.
5. **Local Anesthesia Injection:** "Numbing medicine" carefully used to numb the teeth and surrounding areas prior to certain dental procedures such as tooth removal and dental fillings
6. **Nitrous Oxide:** "Laughing Gas" to help eliminate dental fear, making the patient more comfortable. ***(This service is only offered at Dr. Oates Dental.)***
7. **Dental Rubber Dam:** A sheet of rubber used to carefully isolate the teeth that need dental treatment.
8. **Dental Fillings/Crowns:** Depending on the size of tooth decay, and location of tooth in the mouth, the following may be done. Front teeth: white filling/crown. Back teeth or canine teeth: silver amalgam filling or stainless steel crown.
9. **Pulp (tooth nerve) Treatment/ Root Canal:** A procedure to save baby teeth and certain permanent teeth that would otherwise be lost because of a deep cavity that has affected the tooth nerve. Saving a baby tooth that would normally be expected to remain in the mouth for nine months or more is recommended because it provides the patient with a chewing surface. Also, baby teeth serve as natural space maintainers for the adult teeth growing underneath them. **It is important to complete a final restoration/crown after a root canal on a permanent tooth to prevent reinfection of the tooth.**
10. **Extraction (Removal) of Teeth:** Teeth may be removed because of infection, injury, orthodontic reasons (teeth crowding), or if they are diseased and cannot be saved by any dental procedures.

    Do you wish to be contacted before extractions? ___yes ___no

    If we are unable to contact you and [yes] is circled we will not proceed with treatment that day.
11. **Space Maintainer:** Recommended when baby teeth are lost prematurely. Helps maintain the natural space intended for a permanent tooth by preventing adjacent teeth from drifting together and forcing permanent teeth to erupt in a crowded condition.
12. **Other:** _____

B. The following are the behavior management techniques that may be used on children who do not cooperate in the dental chair. Please note that these techniques are used carefully, and only when necessary.
   1. **Voice Control:** Voice control is a controlled alteration of the voice volume, tone or pace to influence and direct he patient's behavior. The attention of an uncooperative or inattentive child is gained by using a firm tone, changing the tone or increasing the volume of the voice.
   2. **Physical Restraint by the Dentist:** The dentist gently restrains the child from unwanted and unexpected movement by holding down the child's hands or upper body, stabilizing the child's head between the dentist's arm and body or positioning the child firmly in the dental chair.
   3. **Physical Restraint by a Dental Assistant(s):** The assistant(s) gently restrain the child from unwanted and unexpected movement by holding the child's hands, stabilizing the head and/or controlling let movements.
   4. **Mouth Prop:** A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses to open the mouth or has difficulty maintaining an open mouth.
   5. **Papoose Board:** Used only in special cases. This is best described as a "safety robe" or "blanket" allowing the child to feel secure rather than threatened. The papoose board allows the needed dental work to be done while minimizing the possibility of accidental injury to the child due to uncontrolled body movements.

C. The nature and purpose of the treatment and procedures have been explained to me in general terms. Alternate procedures or methods of treatment if any, have been explained to me. I have also had the advantages, disadvantages, risks, consequences and probable effectiveness of each explained to me, as well as the prognosis if no treatment is provided.

D. I am advised that though the results of the treatment are expected to be good, the possibility and nature of complications cannot be accurately anticipated for each individual. Therefore, there can be no guarantee as expressed or implied either of the result of the treatment or of the cure.

E. **Risks and Complications:** Although their occurrence is not frequent, some **risks and complications** are known to be associated with dental or oral surgery procedures. The **more common complications** associated with special needs dental treatment include **nausea** following the administration of **topical fluoride** and patient **biting** and **injuring** their **tongue or lip** following the administration of **local anesthesia. Less common complications** include the risks of numbness, infection, swelling, prolonged bleeding, discoloration of tissues, vomiting, allergic reactions, swallowing or aspiration of dental materials, an extracted tooth or gauze packing; injury to the tongue or lips, damage to and possible loss of existing teeth and or fillings, injury to nerves near the treatment site, and fracture of a tooth root which may require additional surgery for its removal. **For patients with certain heart diseases, the risk of Infective Endocarditis (heart infection) following certain dental procedures exists.** In such cases, the dentist may prescribe antibiotics before treatment begins, to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment that may require hospitalization.

F. I hereby acknowledge that I have read and understand this consent form. I have been given an opportunity to ask any questions that I might have. All questions about the procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions, which may arise during the course of my patient's dental treatment. I also understand that I am free to withdraw my consent to treatment at any time. This consent shall remain in effect until I choose to terminate it.

Do you have any objections? ___No ___Yes If yes, please explain? _____

G. By signing this consent form, I authorize and direct the dentists of Crusader Community Health, Onsite Dental, Park City Dental and/or Oates Dental, assisted by the dental staff of his/her choice, to perform upon my patient (or legal ward for whom I am empowered to consent) the dental treatment or oral surgery procedures explained.
I also hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

H. I understand that each dental provider can only guarantee the work that they do. Therefore, I will not hold a provider liable for dental work completed by a different provider.

If our office begins treatment for this child and cannot complete the care within the time allowed, it is your responsibility to make other arrangements for the care of this child.

Today's date: _____

Patients Name: _____ Date of Birth: _____ Student ID: _____

Name of person completing form: _____ Signature: _____

Your relationship to patient: _____ Daytime Phone: _____

Are you legally responsible for this patient? _____Yes_____No
(If no, we may need a written or oral consent from the person/institution legally responsible for this child.)

Student: _____ ID#: _____ School: _____

Birthdate: _____ Gender: _____ Grade: _____ Room: _____

ROCKFORD PUBLIC SCHOOLS

Consent to Release Information, Confidentiality & Privacy, Assignment of Benefits, and for Transportation

The Board of Education of the Rockford Public Schools, District No. 205 ("District No. 205") has arranged with Onsite Dental Dental, PC Services/Park City Dental, Dr. Oates Dental, and Crusader Community Health ("Service Organizations") to provide dental services for eligible District No. 205 students. I understand I am providing this Consent for the purpose of obtaining professional dental services for my child listed below and for the other purposes described in this Consent. I further understand this Consent covers only dental services provided by the Service Organizations, and that each service organization can only be held liable for the services they perform.

Acknowledgment of Release of Information

By signing this consent, I authorize District No. 205, the Service Organizations, their individual service providers and their supervisors to exchange and discuss appropriate information pertaining to my child only when needed for my child's treatment. I also authorize the Service Organizations to communicate with my child's regular primary care provider and/or dentist.

Emergency Contact/Changes in Health Status or Custody

I understand that as a condition of this Consent, if any of the Service Organizations judge my child to be a serious danger to him/herself or others, then the Service Organization(s) reserves the right to inform a physician, others who may be at risk, designated emergency contacts and appropriate emergency services. I further agree that I will promptly inform the School Based Dental Center staff in writing of 1) any change in my child's physical or dental health and 2) any change in the custody or guardianship of my child which affects my ability to provide this Consent on behalf of my child.

Child's Name: (Last) _____, (First) _____ (M.I.) _____

Child's Date of Birth: _____ Student ID #: _____

Confidentiality & Privacy

I understand the Service Organizations will protect the privacy of my child's health and educational records to the extent required by federal and state law. I understand that I may revoke this authorization at any time (except to the extent that any Service Organization has already taken action based upon my prior consent) if I make a written statement revoking the authorization and deliver it to Rockford Public School District No. 205, Attn: Health Services, 501 7th St., Rockford, IL 61104.

Assignment of Benefits

I hereby assign to the Service Organizations any and all payments to which I am entitled under Medicaid or any health insurance policy for health care or dental health services rendered to my child by any Service Organization as long as the charges for services by the Service Organization(s) do not exceed the Service Organization's regular charges. I further authorize each Service Organization to bill and receive payment directly from Medicaid or my insurance carrier(s) for those services that the Service Organization delivered and for which I may be entitled to insurance coverage. I also authorize each Service Organization to give to Medicaid or my health insurance carrier(s) any information necessary for billing purposes for services provided for such periods of time as my child has received or is receiving primary health care or dental health services.

Continued on back >>>

Agreement Concerning Transportation to and from Service Organization

Dental services for students being transported by District No. 205 are provided at one of the following:

Park City Dental	Dr. Oates Dental	Crusader Community Health
555 N. Court St., Suite 100 Rockford, IL 61103 (815)708-6556	3957 N. Mulford Rd., Suite 1 Rockford, IL 61114 (815)637-6400	1100 Broadway, Rockford, IL 61104 1200 W. State St., Rockford, IL 61102 6115 N. 2nd St., Loves Park, IL 61111 1002 N. Pierpont Av., Rockford, IL 61101 (815)490-1374/(815)490-1428

District No. 205 will transport eligible students to and from District No. 205 schools and the Service Organization's clinic.

a) If my child needs transportation as indicated below, I consent to having one of the Service Organizations schedule District No. 205 transportation to take my child to and from District No. 205 for dental services, at no cost to me.
b) I agree that District No. 205 may seek reimbursement from Medicaid for such transportation services.

If My Child Is Seen At The End Of The School Day, My Child:

- ☐ May walk home with their siblings (named) _____
- ☐ May walk home with a friend(s) (named) _____
- ☐ Should be transported to babysitter / child care provider named located at with this telephone number: _____
- ☐ Should be transported home.

My signature below indicates my permission for my child (first and last name of child: _____ _____) to participate in the student travel/activity described above as well as my agreement to the terms set forth above. My signature also indicates that I have read and approve the medical treatment authorization.

I, (parent or guardian name) _____, have read the above material and understand its meaning. My signature below is an acknowledgment that I have reviewed this form, understand the information and consent to all of the actions described above. My signature also attests to the accuracy of the information provided on both sides of this form.

Signature of Parent/Guardian: _____ Date: _____

Daytime Phone: _____

Parents are encouraged to attend their child's appointments. For questions about dental services or to reschedule your child's dental appointment, please call at least 24 hours prior to appointment time at (815)966-3166.