



DENTAL CLINIC

Bethany for Children & Families Give Kids a Smile Mobile Dental Clinic provides oral health education, dental exams, teeth cleaning, fluoride, and sealants if needed. Participants also receive a toothbrush, toothpaste, and floss.

Please fill out the attached permission form CLEARLY, including insurance information and return the second page only to your student's teacher or nurse.

If you have any questions please contact your school nurse or the Give Kids a Smile Dental Program Manager, Melody Mosenfelder. Phone (309) 581-6211
Email: mmosenfelder@bethany-qc.org

FUN FACT:

The tooth is the only part of the human body that can't repair itself!



TEAR OFF AND KEEP THIS PAGE FOR YOUR RECORDS

GIVE KIDS A SMILE NOTICE OF PRIVACY PRACTICES



THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Dentists participating in the Give Kids a Smile program may be required by applicable federal and state law to maintain the privacy of your health information. Protection of patient privacy is important to participants in the Give Kids a Smile program. This notice summarizes the privacy practices that will be followed by participants in the Give Kids a Smile program, and your rights concerning your health information. This Notice will apply to health information collected in connection with the Give Kids a Smile program and will remain in effect until replaced.

You may request a copy of the Notice of Privacy Practices at any time. For more information about the privacy practices, or for additional copies of this Notice, please contact Bethany for Children & Families at (309) 797-7700.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment. For example, we may use or disclose your health information to another dentist, physician, or other health care provider providing treatment to you.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person involved in your treatment to the extent necessary to help with your health care.

Persons Involved in Care: We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us at (309) 797-7700 for assistance in reaching the dentist or facility holding your health information.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last six years, but not before April 14, 2003.

Restriction: You may request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You may request that we communicate with you about your health information by alternative means or to alternative locations. We may agree to reasonable requests.

Amendment: You may request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS & COMPLAINS

If you want more information about our privacy practices or have questions or concerns, please contact us at (309) 797-7700. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your health information, or to have us communicate with you by alternative means or at alternative locations, you may contact us at (309) 797-7700. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

— — — **TEAR OFF AND KEEP THIS PAGE FOR YOUR RECORDS** — — —

GIVE KIDS A SMILE — PERMISSION FORM
PLEASE PRINT IN INK & RETURN TO SCHOOL



/ / M F

Student's First Name **Student's Last Name** **Date of Birth** **Gender**

Home Address **City** **State** **Zip Code**

Parent/Guardian First Name **Last Name** **Phone** **Email Address**

Emergency Contact Name **Relationship to Student** **Emergency Contact Phone**
(If other than Parent/Guardian)

Student's School **Student's Counselor** **Student's Grade**

Primary Insurance Provider **MEMBER ID #**

Secondary Insurance (if any): _____

<p>What race do you consider your child?</p> <p><input type="checkbox"/> Black</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Hispanic / Latino</p> <p><input type="checkbox"/> Asian / Pacific Islander</p> <p><input type="checkbox"/> American Indian / Native Alaskan</p> <p><input type="checkbox"/> Multi-Racial</p> <p><input type="checkbox"/> Other _____</p>	<p>What type of <u>DENTAL INSURANCE</u> does your child have? (check all that apply)</p> <p><input type="checkbox"/> Private dental insurance</p> <p><input type="checkbox"/> Delta Dental /Hawk-i</p> <p><input type="checkbox"/> Medicaid (Medical Card, Title 19)</p> <p><input type="checkbox"/> Envolve/Meridian</p> <p><input type="checkbox"/> Dentaquest/Molina/BCBS/Aetna</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> None</p>	<p>My child's most recent dental visit was within the past:</p> <p><input type="checkbox"/> 0-6 months</p> <p><input type="checkbox"/> 1-3 years</p> <p><input type="checkbox"/> Never seen a dentist</p> <p><input type="checkbox"/> Unsure</p> <hr/> <p>Has your child been seen in the Give Kids a Smile Mobile Dental Clinic before?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
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For Office Use Only: Found info in: HFS Dentaquest Envolve MCNA Delta Hawk-I other: _____

Verified Insurance Provider/Company (ie. Aetna): _____

Last Exam Date: ____/____/____ **Sealants: Y or N** **List Date of Sealants & teeth next page**

GIVE KIDS A SMILE — PERMISSION FORM



Bethany
for Children & Families



PLEASE CHECK IF YES

<input type="checkbox"/> Needs an antibiotic before a dental procedure.	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Nut Allergy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Latex Allergy
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Tobacco/drug use
<input type="checkbox"/> Cancer	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Speech Difficulties
<input type="checkbox"/> Drinks Bottled Water	<input type="checkbox"/> Fainting/Dizziness
<input type="checkbox"/> Drinks City Water	<input type="checkbox"/> Hearing Difficulties
<input type="checkbox"/> Drinks Well Water	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Medication — Please list	<input type="checkbox"/> Concerns with mouth or teeth:
_____	_____
_____	_____

For Office Use Only

Sealants Placed & Date:

<input type="checkbox"/> 2	___/___/___
<input type="checkbox"/> 3	___/___/___
<input type="checkbox"/> 14	___/___/___
<input type="checkbox"/> 15	___/___/___
<input type="checkbox"/> 18	___/___/___
<input type="checkbox"/> 19	___/___/___
<input type="checkbox"/> 30	___/___/___
<input type="checkbox"/> 31	___/___/___

Health History Reviewed By: _____

Hygienist's Initials: _____

Dentist's Initials: _____

Date: _____

PLEASE READ THE CONSENTS BELOW:

I give permission for my student to receive dental treatment and allow the school nurse, school representative, and dental provider to access the student's dental record.

I give permission to Bethany for Children & Families to phone, text and/or email me regarding my student's health services information.

I understand that in the rare circumstance that Bethany for Children & Families needs to transport my student from his/her school to the mobile dental clinic I will be contacted for verbal consent. (There are times that we split the day with a nearby school and your student may need to be transported by an authorized Bethany representative to the location of the mobile dental clinic.)

I give permission for Bethany for Children & Families to release, obtain, or exchange information manually and/or via an electronic platform with the I-Smile Program and/or other dental provider.

I give permission for my student's sealants to be checked and resealed if needed. (These are called IDPH Quality Assurance Audits.) They are performed by professional providers that may need to return to my student's school to recheck his or her sealants and reseal if needed on days that the mobile dental clinic is present.

My signature grants permission for the above consents and authorizes the dental provider to treat and bill for services performed in the mobile dental clinic. I have received a copy of the privacy practices.

Signature for "YES": _____ Date: _____

Signature for "NO": _____ Date: _____

Permission and acknowledgment is valid one year from the date of signature.