Dental Care at School!

If your child has Medicaid/CHIP, the service is 100% COVERED.
MEDICAID/CHIP: Complete THIS side of form ONLY

3 EASY STEPS

1. **Fill in all the information in pen.**
2. **Sign next to the ✓ at the bottom. Signed consent includes initial visit, follow-up & 6-month visits when appropriate.**
3. **Have your child return this permission slip to his/her teacher RIGHT AWAY!**

School or Program Name ____________________ County ____________

Teacher ____________________ Room # ______ Grade ______

Child's Legal Name ____________________ Child's Soc. Sec. # ___-__-____

Parent/Guardian Name ____________________ Child's Date of Birth ____________

Relationship to child ____________ Cell/Phone ( ) ____________ Email ____________

Address ____________________ City ____________ Zip ______

Medicaid/Pennsylvania CHIP

Private insurance or self-pay: Complete OTHER side ONLY

We accept Medicaid, Pennsylvania CHIP.

Please circle one of the following: Medicaid, Gateway, United Healthcare, Keystone, Amerihealth, UPMC, Health Partners, Geisinger CHIP, Aetna, United Concordia CHIP, Coventry Cares, Kidz Partners

Child's Recipient ID Number (RIN): ____________________

Health History: Check as "YES" each condition that may apply to your child. (New form required if health/dental history changes.)

- ☐ Allergies (list below)
- ☐ Asthma
- ☐ Diabetes
- ☐ Latex Allergy
- ☐ Heart Murmur (requiring pre-medication)
- ☐ Hemophilia
- ☐ Blood Disorders
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Heart Murmur (NOT requiring pre-medication)
- ☐ Seizures
- ☐ Shunts or Artificial Joints
- ☐ Kidney Problem
- ☐ Tuberculosis
- ☐ Heart Valve Replacement
- ☐ Other (explain below)

Dental conditions/problems/thumbsucking, etc. ____________________ Date of last dental visit ______

Use space below to provide additional details on your child's health, including any allergies. List current medications. Attach another page as needed.

I am the custodial parent or legal guardian of the above child and I authorize Big Smiles Pennsylvania P.C. and its affiliated dentists to provide dental care which may include, but is not limited to dental exams, x-rays, cleanings, fluoride, sealants, fillings, crowns, pulpotomies and simple extractions of baby teeth at school without my presence or further notification or consent unless I timely withdraw this consent. This signed consent authorizes the initial visit, follow-up and 6-month visits when appropriate, as well as the release of my child's most recent health information as provided to the school/facility. I further agree that the extent of the dental care to be provided is at the sole discretion of the treating dentist. I authorize and direct Big Smile Pennsylvania P.C. to bill and collect payment from any Medicaid, insurance or other third party payer that covers the services provided to this patient, which shall be applied to the patient's benefits. I understand that, in some cases, the dental treatment may not be able to be finished at school due to complexity, time constraints, or the child's behavior. I may be contacted at the address and/or phone number provided on this application form if a referral is necessary for additional treatment. If I have any questions about the dental care, or any possible complications of the dental care provided or to be provided, then I will call the number below. I acknowledge receiving a notice of privacy practices attached to this consent form. (Please keep the HIPAA privacy form for your records.)

✓ ____________________________________

Signature of Custodial Parent/Legal Guardian Date

If the child has a dentist, you may wish to continue dental services with that provider. To avoid dental service or benefit duplication, please inform your dentist which services were performed at school. (See oral health report card, provided after school dental visit, which will indicate services provided.)

OFFICE USE ONLY:		
IOE	6 mo	
		exam, prophy
		fluoride
		(4) bwx or (2) bwx and diag. films
		diag. films only
		seal (M)molars or (MB)molars and bicuspids
		(✓) csf or (so)screen only

Elliot P. Schlang, D.D.S., General Dentist & Dental Director, Big Smiles Pennsylvania P.C., 200 Barr Harbor Dr., Ste. 400-4079, West Conshohocken, PA 19428

Visit us at: mobiledentists.com Phone:1-888-833-8441 Fax:1-888-330-4331

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Smile Pennsylvania
...the mobile dentists

Dental Care at School!

PRIVATE INSURANCE, SELF-PAY, GRANT REQUESTS: Complete THIS side ONLY

3 EASY STEPS

1. **Fill in all the information in pen.**
2. **Sign next to the ✓ at the bottom. Signed consent includes initial visit, follow-up & 6-month visits when appropriate.**
3. **Have your child return this permission slip to his/her teacher RIGHT AWAY!**

School or Program Name__________ County__________

Teacher__________ Room #_____ Grade_____

Child's Legal Name__________ Child's Soc. Sec. # ___-__-____

Parent/Guardian Name__________ Child's Date of Birth__________

Relationship to child__________ Cell/Phone ( )__________ Email__________

Address__________ City__________ Zip__________

Private Dental Insurance Information

MEDICAID/CHIP: Complete OTHER side ONLY

Company name (other than Medicaid) __________ Ins. phone __________

Group # __________ Employer name __________ Co. phone __________

Name of person under whom child is covered __________ **BIRTH DATE of Insured Adult** __________

Contract ID # __________ Social Security # of insured adult __________

Medicaid or Pennsylvania CHIP as secondary insurance

Child's Recipient I.D. # __________

No Medicaid or Dental Insurance (check ONE box only)

☐ I am able to pay the full fee for a dental cleaning, screening & fluoride per visit.
Ages 11 or younger: **$80.00** Ages 12 or older: **$100.00**
Please make check or money order payable to **Smile Pennsylvania** & staple to this form.

☐ Check here if you need financial aid for insurance co-pays/deductibles, if any.

☐ I need to pay for a subsidized service because I am unable to pay full fee. It will cover dental cleaning, screening & fluoride.
Ages 11 or younger: **$48.00** Ages 12 or older: **$54.00**
Please make check or money order payable to **Smile Pennsylvania** & staple to this form.

☐ I certify that I am unable to pay the full or subsidized fee and request full financial assistance, which will cover dental cleaning, screening & fluoride (grants unavailable for restorative care). We will mail you a grant application. Grants are available only once per school year.

Health History: **Check as "YES" each condition that may apply to your child. (New form required if health/dental history changes.)**

☐ Allergies (list below) ☐ Asthma ☐ Diabetes ☐ Latex Allergy ☐ Heart Murmur (requiring pre-medication)
☐ Hemophilia ☐ Blood Disorders ☐ Hepatitis ☐ HIV/AIDS ☐ Heart Murmur (NOT requiring pre-medication)
☐ Seizures ☐ Shunts or Artificial Joints ☐ Kidney Problem ☐ Tuberculosis ☐ Heart Valve Replacement ☐ Other (explain below)

Dental conditions/problems/thumbsucking, etc. __________ Date of last dental visit __________

Use space below to provide additional details on your child's health, including any allergies. List current medications. Attach another page as needed.

I am the custodial parent or legal guardian of the above child and I authorize Big Smiles Pennsylvania P.C. and its affiliated dentists to provide dental care which may include, but is not limited to dental exams, x-rays, cleanings, fluoride, sealants, fillings, crowns, pulpotomies and simple extractions of baby teeth at school without my presence or further notification or consent unless I timely withdraw this consent. This signed consent authorizes the initial visit, follow-up and 6-month visits when appropriate, as well as the release of my child's most recent health information as provided to the school/facility. I further agree that the extent of the dental care to be provided is at the sole discretion of the treating dentist. I authorize and direct Big Smile Pennsylvania P.C. to bill and collect payment from any Medicaid, insurance or other third party payer that covers the services provided to this patient, which shall be applied to the patient's benefits. If I have private dental insurance, I will be billed for and agree to pay any deductibles and/or co-pays. (See above for financial aid.) I understand that, in some cases, the dental treatment may not be able to be finished at school due to complexity, time constraints, or the child's behavior. I may be contacted at the address and/or phone number provided on this application form if a referral is necessary for additional treatment. If I have any questions about the dental care, or any possible complications of the dental care provided or to be provided, then I will call the number below. I acknowledge receiving a notice of privacy practices attached to this consent form. (Please keep the HIPAA privacy form for your records.)

✓ __________
Signature of Custodial Parent/Legal Guardian Date

If the child has a dentist, you may wish to continue dental services with that provider. To avoid dental service or benefit duplication, please inform your dentist which services were performed at school. (See oral health report card, provided after school dental visit, which will indicate services provided.)

OFFICE USE ONLY:		
IOE	6 mo	
		exam, prophy
		fluoride
		(4) bwx and diag. films
		diag. films only
		seal perm molars
		seal perm molars and bicuspids
		csf

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Visit us at: mobiledentists.com Phone:1-888-833-8441 Fax:1-888-330-4331

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Cuidado Dental en la Escuela!

Si su niño(a) tiene Medicaid/CHIP, los servicios están 100% CUBIERTOS.
MEDICAID/CHIP: Complete ESTE lado de la forma solamente

3 Pasos Fáciles

1. **Llene toda la información con pluma.**
2. **Firme enseguida de ✓ en la parte de abajo. Este consentimiento firmado incluye Visita inicial. Seguimientos y Visita de 6-meses cuando sea apropiado.**
3. **Haga que su niño(a) regrese esta forma de permiso a su maestro(a) inmediatamente!**

Nombre de la Escuela o Programa ______________________ Condado ______________

Maestro(a) ______________________ # Salón ________ Grado ________

Nombre Legal del Niño(a) ______________________ # de Seguro Social de su Niño(a) ___ ___ ___-___ ___-___ ___ ___ ___

Nombre del Padre/Tutor ______________________ Fecha de Nacimiento ______________

Relacion al Niño(a) ______________ Celular/Tel (   ) ______________ Email ______________

Direccion ______________________ Ciudad ______________ Codigo Postal ______________

Medicaid/Pennsylvania CHIP — Seguro dental privado o "Auto-pago": Llene el OTRO lado solamente

Aceptamos Medicaid, Pennsylvania CHIP.

Por favor seleccione con un circulo uno de los siguientes: Medicaid, Gateway, United Healthcare, Keystone, Amerihealth, UPMC, Health Partners, Geisinger CHIP, Aetna, United Concordia CHIP, Coventry Cares, Kidz Partners

10 Números del Recipiente (RIN): ______________________

Historia Medica: **Seleccione todas las condiciones que apliquen a su niño(a). (Una forma nueva es requerida si la historia medica a cambiado.)**

☐ Alergias (liste abajo) ☐ Asma ☐ Diabetes ☐ Alergia al látex ☐ Soplo en el Corazón (Requiere pre-medicamento)
☐ Hemofilia ☐ Problemas de sangre ☐ Hepatitis ☐ VIH/SIDA ☐ Soplo en el Corazón (NO requiere pre-medicamento)
☐ Ataques epilépticos ☐ Derivación o coyunturas artificiales ☐ Problemas de los riñones ☐ Tuberculosis ☐ Reemplazo de válvula del corazón ☐ Otro (explique abajo)

Condiciones/Problemas dentales, etc. ______________________ Fecha de última visita al Dentista ________

Use el espacio de abajo para darnos información adicional sobre la salud de su niño(a), incluyendo alergias. Liste cualquier medicamento. Adjuntar otra hoja si es necesario.

____

Soy el padre custodio o tutor legal del niño(a) en cuestión y autorizo a Big Smiles Pennsylvania P.C., y a sus dentistas afiliados a proveer servicios dentales los cuales pueden incluir, pero no se limitan a, examen dental, rayos x, limpieza, fluoruro y sellantes sin mi presencia o notificación o consentimiento al menos que retire este permiso a tiempo. Este consentimiento firmado autoriza la visita inicial, seguimiento o visita de 6 meses cuando sea apropiado, también libera la información medica mas reciente de mi niño(a) dada a la escuela/facilidad. También estoy de acuerdo que el trato y cuidado dental a ser proveído será exclusivamente a la discreción del dentista que trate a su niño(a). Autorizo y dirijo a Big Smiles Pennsylvania P.C., a facturar y recolectar pago de Medicaid, seguro privado o tercera persona que cobra los servicios proveídos a los cuales serán aplicados a los beneficios del paciente. Si tengo seguro dental privado, seré facturado y acuerdo a pagar deducibles y/o co-pagos. (Vea arriba para ayuda financiera.) Entiendo que, en algunas ocasiones, el tratamiento dental no podrá ser finalizado en la escuela debido a lo complejo de el tratamiento, restricciones de tiempo o comportamiento del niño(a). Podré ser contactado a la dirección o numero de teléfono proveído en esta aplicación si una referencia es necesaria para tratamiento adicional. Si tengo alguna pregunta sobre el cuidado dental o alguna posible complicación del cuidado dental proveído o a ser proveído, entonces llamare al número de abajo. Admito haber recibido la notificación de prácticas privadas adjunta a esta hoja de consentimiento. (Por favor retenga la forma de privacidad HIPAA para sus archivos.)

✓ ____

Fima del Padre/Madre Custodio o Tutor Legal   Fecha

OFFICE USE ONLY:		
IOE	6 mo	
		exam, prophy
		fluoride
		(4) bwx or (2) bwx and diag. films
		diag. films only
		seal (M)molars or (MB)molars and bicuspids
		(✓) csf or (so)screen only

Si su niño(a) ya tiene dentista, tal vez desee seguir el cuidado dental con ese proveedor. Para evitar duplicados en el servicio dental o beneficios, por favor infórmele a su dentista cuales servicios fueron hechos en la escuela. (Vea la tarjeta del reporte de salud oral proveída después de la visita dental en la escuela la cual indica los servicios proveídos.)

Elliot P. Schlang, D.D.S., General Dentist & Dental Director, Big Smiles Pennsylvania P.C., 200 Barr Harbor Dr., Ste. 400-4079, West Conshohocken, PA 19428

Visitenos en: mobiledentists.com   Teléfono:1-888-833-8441 Fax:1-888-330-4331

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Smile Pennsylvania
...Los dentistas móviles

Cuidado Dental en la Escuela!

SEGURO DENTAL PRIVADO, AUTO-PAGO, AYUDA: Complete ESTE lado SOLAMENTE

3 Pasos Fáciles

1. **Llene toda la información con pluma.**
2. **Firme enseguida de ✓ en la parte de abajo. Este consentimiento firmado incluye Visita inicial, Seguimientos y Visita de 6-meses cuando sea apropiado.**
3. **Haga que su niño(a) regrese esta forma de permiso a su maestro(a) inmediatamente!**

Nombre de la Escuela o Programa ____________ Condado ____________
Maestro(a) ____________ # Salón ______ Grado ______
Nombre Legal del Niño(a) ____________ # de Seguro Social de su Niño(a) ___-__-____
Nombre del Padre/Tutor ____________ Fecha de Nacimiento ____________
Relacion al Niño(a) ________ Celular/Tel ( ) ________ Email ____________
Direccion ____________ Ciudad ____________ Codigo Postal ______

Informacion del Seguro Privado

MEDICAID/CHIP: Complete El otro lado

Nombre de la Compañía (aparte Medicaid) ____________ Tel del seguro ____________
Grupo # ____________ Nombre del Empleador ____________ Tel de la Compañía ____________
Nombre de la persona mediante la cual el niño(a) esta cubierto ____________ **Fecha de Nacimiento del Adulto asegurado** ____________
Contrato / ID # ____________ # De Seguro Social del adulto asegurado ____________
Medicaid o Pennsylvania CHIP como seguro secundario
Del niño(a) recipiente ____________

No Medicaid o Seguro Dental (Solo Seleccione UNA Opción)

☐ Puedo pagar el precio completo por una limpieza dental, revisión y fluoruro por visita.
11 años o menos: **$80.00** 12 años o mas: **$100.00**
Por favor haga su cheque personal o giro postal a **Smile Pennsylvania** y engrape a esta hoja.

☐ Necesito pagar por servicios subsidiados por que no puedo pagar el precio completo. Cubrirá la limpieza, revisión y fluoruro.
11 años o menos: **$48.00** 12 años o mas: **$54.000**
Por favor haga su cheque personal o giro postal a **Smile Pennsylvania** y engrape a esta hoja.

☐ Seleccione si necesita ayuda financiera con el co-pago o deducible de su seguro dental si existe alguno.

☐ Certifico que no puedo hacer el pago complete o subsidiado y pido asistencia completa ayuda financiera, la cual cubrirá limpieza dental, revisión y fluoruro (asistencia financiera disponible para tratamiento restorativo). Nosotros le mandaremos una aplicación para recibir ayuda financiera la cual solo esta disponible una vez por año.

Historia Medica: **Seleccione todas las condiciones que apliquen a su niño(a). (Una forma nueva es requerida si la historia medica a cambiado.)**

☐ Alergias (liste abajo) ☐ Asma ☐ Diabetes ☐ Alergia al látex ☐ Soplo en el Corazón (Requiere pre-medicamento)
☐ Hemofilia ☐ Problemas de sangre ☐ Hepatitis ☐ VIH/SIDA ☐ Soplo en el Corazón (NO requiere pre-medicamento)
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Condiciones/Problemas dentales, etc. ____________ Fecha de última visita al Dentista ______

Use el espacio de abajo para darnos información adicional sobre la salud de su niño(a), incluyendo alergias. Liste cualquier medicamento. Adjuntar otra hoja si es necesario.

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✓ ____________
Fima del Padre/Madre Custodio o Tutor Legal Fecha

OFFICE USE ONLY:		
IOE	6 mo	
		exam, prophy
		fluoride
		(4) bwx and diag, films
		diag. films only
		seal perm molars
		seal perm molars and bicuspids
		csf

Si su niño(a) ya tiene dentista, tal vez desee seguir el cuidado dental con ese proveedor. Para evitar duplicados en el servicio dental o beneficios, por favor infórmele a su dentista cuales servicios fueron hechos en la escuela. (Vea la tarjeta del reporte de salud oral proveída después de la visita dental en la escuela la cual indica los servicios proveídos.)

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Visitenos en: mobiledentists.com **Teléfono:1-888-833-8441 Fax:1-888-330-4331**

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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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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 to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to 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 have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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

Contact Officer: HIPAA Officer

Telephone: 1-888-833-8441 Fax: 1-888-330-4331

E-mail: caringdental@mobiledentists.com

Address: 200 Barr Harbor Dr., Ste. 400-4079, West Conshohocken, PA 19428