School Smiles
On-site Dental Care

1499 Windhorst Way, Suite 100 · Greenwood, IN 46143 · Phone: 1.855.49**SMILE** · Fax: 888.781.5678

# SCHOOL SMILES ON-SITE DENTAL PROGRAM

## Does your child have a current dentist?

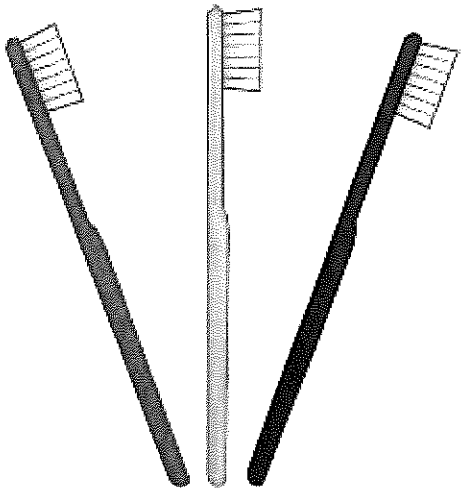
**NO?** Please fill out the attached form **TODAY** and return to your child's school by **April 1, 2016**

**School Smiles On-Site Dental Program Provides:**

- Continuous dental care provided by a state licensed dentist at school during school hours
- All services provided within the safety of the school with minimal classroom time lost.
- Routine dental check-ups scheduled every 6 months.
- Restorations, Crowns, and Dental Hygiene Instructions.
- Free toothbrushes, toothpaste, floss, and other dental supplies to those enrolled!

**We accept Medicaid, most private insurance plans, and offer Grant Scholarship Funds for those uninsured on a first-come-first-served basis.**

**If your child is currently enrolled in our program, a NEW form must be completed each school year!**

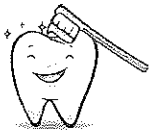


**School Smiles can become your child's Dental Home!**

We take care of all necessary paperwork and insurance billing.

**Should you have any questions, please feel free to contact us at 1.855.497.6453**

PLEASE COMPLETE ENTIRE FORM, FRONT AND BACK



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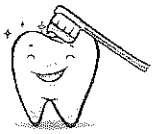

# Your School's On-site Comprehensive Dental Care Provider

**A NEW FORM MUST BE COMPLETED EACH SCHOOL YEAR!**
**Please fill form out COMPLETELY to ensure your child is able to be seen!**

**Do you have a Current Dentist: Y N**
If you do not want to switch your child to be seen by our dentist at school **DO NOT** complete this form.

## General and Health Information

Child's Legal Name: (first) _____ (M.I) _____ (last) _____

School: _____ County: _____ (circle) M F

Child's Birthdate: ____/____/____ Age: _____ Grade: _____ (circle) AM PM

Address: _____ City: _____ State: ____ Zip Code: _____

Phone: ( )_____ Email: _____

Your child's Social Security number: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

Does this child have any or ever had any of the following diseases, medical conditions or procedures? ☐ NONE

Y N Shunts or artificial joints
Y N Asthma
Y N Hemophillia
Y N Blood Disorder
Y N Diabetes
Y N HIV/AIDS
Y N Heart Valve Replacement
Y N Heart murmur (not requiring pre-medication)
Y N Heart murmur (requiring pre-medication)
Y N Other _____

**Is your child alergic to:** (circle) Latex Penicillin/Amoxicillin Dental Anesthetics (Novocaine) Aspirin Food Allergies Seasonal Other:_____

**Pharmacy Phone #:** ( )_____ **Child's Weight:** _____

## Payment Information: Must be filled out for child to be seen

**Medicaid** ☐ **Private Insurance** ☐ **Self Pay: $99** ☐

**Managed Care Plan:** Caresource ☐ Aetha ☐ Molina ☐ UHC ☐ Paramount ☐ Buckeye ☐

Child's 12-digit **Medicaid** Recipient ID Number:
If Caresource, MUST list Caresourse ID#, All others list OH Medicaid #

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## Private Insurance Information: Please complete entire section and include copy of DENTAL Insurance Card.

**Name of Private Dental Insurance Company** _____ Ins. Phone: _____

Group number: _____ Employer name: _____ Co. Phone: _____

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

Social Security number of insured adult: ___ ___ ___-___ ___-___ ___ ___ ___ Contract/ID number: _____

Secondary Insurance information Insurance Name:_____ Policy Holder: _____ Date of Birth:_____

ID Number:_____ Employer Phone:_____ Insurance Co. Phone #: _____

**Financial Statement: Please be aware that any treatment that is rendered may affect future benefits that your child will recieve under: private insurance, health insurance program, Medicaid, and Hoosier Healthwise**

## Self-Pay Option/Payment Information

I wish to pay out of pocket for my child to recieve a dental exam, x-rays, cleaning, and fluoride. Fee $99.

For a complete list of our fees, please visit our website: www.schoolsmiles.com

Payment Method: (circle) **Cash Check Debit/Credit**

*Please make checks and money orders payable to: School Smiles*

**Grant Funds available on first come first serve basis** (please check if interested in applying) ☐

## Important: Parent/Guardian Signature Required

*If you wish to have your child participate in this program, please sign and complete both sides of this form. If you have any questions regarding your child's dental health, you may contact us directly at 1.855.49SMILE, or please feel free to visit our website at www.schoolsmiles.com for further information and frequently asked questions. Initial signed consent includes initial visit (exam,x-rays,cleaning,fluoride, and sealants as needed) for routine and 6 month check-ups. Any additional treatment, beyond the initial visit (fillings/restorations,simple extractions and crowns) will require additional consent and a treatment plan will be sent home. If your child requires treatment outside of what can be provided by School Smiles, a referral will be provided to you.*

***Please complete and sign below and return to your child's teacher.***

I the Parent/Guardian give permission for my child (print child's name)_____to recieve dental treatment from the School Smiles dental providers at their school during school hours.

_____ _____ _____
**Parent/legal guardian signature** Date Child's age

1.855.49SMILE **Front and back of form must be signed.** www.schoolsmiles.com →

PLEASE COMPLETE ENTIRE FORM, FRONT AND BACK

## Notice of Privacy Policies

***School Smile's*** Legal Responsibilities: As mandated by federal and State legal requirements, your child's health information must be protected. We are required to ensure you are aware of privacy policies, legal duties and your rights to our protected health information. This notice of privacy policies, outlined below, will be in effect for the duration of treatment and must be followed by our practice.

We reserve the right to modify our privacy policies and the terms of this notice at any time and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience, information regarding how you can contact us is at the bottom of the notice.

## Protected Health Information Use and Disclosure

Information regarding your child's health may be used and disclosed for the purpose of treatment, payment and other health care operations. Examples cited below further explain the use and disclosure process.

**TREATMENT:** Use and disclosure of your child's protected health information may be provided to a physician or other health care provider providing treatment to your child. If your child has a current dentist, you may wish to continue treatment with that provider.

**PAYMENT:** Your child's protected health information may be used and disclosed to obtain payment for services we provided to your child.

**EMERGENCIES:** We may disclose your child's health information to notify or assist in notifying a family member or another person responsible for their care, about your child's medical condition in the event of an emergency or of your child's death.

**REQUIRED BY LAW:** Your child's protected health information may be used or disclosed if required by law. For example, for public health reasons in relation to disease, disability reporting child abuse or neglect, reporting domestic violence, reporting Food and Drug Administration problems and reactions to medications and reporting disease or infection exposure.

**PUBLIC SAFETY/LAW ENFORCMENT:** Your child's health information may be disclosed to law enforcement for purposes of identifying or locating a suspect, fugitive, or missing person; or in the event of a serious imminent threat to the health and safety of a person or the general public.

**APPOINTMENT REMINDERS:** Your child's protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards and letters.

## Patient Rights

**ACCESS:** You have the right at all times to review your child's protected health information, with limited exceptions. At your written request, we will provide you with your child's information. You have the right to have your child's health information received or communicated through alternative method or sent to an alternative location other than usual method of communication or delivery upon request. You have a right to receive an accounting of disclosures of your child's protected health information made by this practice.

**RESTRICTIONS:** You have the right to request restrictions on certain uses and disclosures of your child's health information. Please be advised; however, that we are not required to agree to the restriction you requested. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

**AMMENDMENT:** You can initiate a written request to amend your child's protected health information. Included in this amendment must be an explanation why information should be amended. Certain conditions may exist where we reject your request.

**QUESTIONS/COMPLAINTS:** Questions or complaints about your privacy rights or how your child's health information has been handled, please contact:

**School Smiles**
**Luis Garabis, DDS**
1499 Windhorst Way, Suite 100
Greenwood, IN 46143
Phone: 1.855.49SMILE
Fax: 888.781.5678
Contact us at: contactus@schoolsmiles.com

If you are not satisfied with the way in which your complaint is handled, you may file a formal complaint with the U.S. Department of Health and Human Services.

***Privacy of your child's protected health information remains extremely important, and we are committed to ensure your privacy.***

***I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my child's health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.***

_____
Patient's Name (PRINTED)

_____ _____
Parent or Guardian's Signature Date