Dear Parents,

Cornerstone Care is committed to keeping your child safe during these trying times. We understand the new norm is scary and ever changing. Cornerstone Care has put in place cleaning protocols that will allow your student to utilize our dental services while protecting them and our staff.

Each employee is screened at the beginning of each workday. They are asked a series of questions related to symptoms of the Corona Virus along with being screened for a fever. Any employee that *has a fever or has any symptoms must return home to quarantine until the symptoms have subsided or a negative test has been produced.

While at the school, all staff will be required to wear a mask. The hygienist and dentist will be wearing a mask, face shield, gloves, jacket, and hair cover while seeing each student.

Each day the Mobile Dental Unit is sterilized from the day before. When students arrive to the dental unit, they will have their temperature screened with a no touch thermometer. The student will then be directed to the dental chair to limit staff interaction and touching multiple surfaces. Once the student has had their services completed, they will be escorted back to the school. At that time the hygienist or dentist will sterilize the dental room:

- All products used that are disposable will be placed in a covered trash container
- All surfaces will be sterilized with Optim 1 wipes (chair, stool, light, countertops, hygienist cart, laptop, pens)
- Instruments will be placed in a sterilization pouch to be run in the sterilizer

This process will occur after each student leaves the dental unit. At the end of the day the entire unit is sterilized:

- Floor is swept and moped
- All walls, doors, reception bench, counter, and chair are sterilized with Optim 1 wipes
- Sterilizer is run to disinfect instruments used for cleanings
- Trash is properly disposed of

With all that is going on right now, our goal is to continue offering our services to those in need while following all guidelines set by the CDC and Cornerstone Care. If you have any questions or concerns please feel to contact Bridget Haas at 724-802-0142 or at bhaas@cornerstonecare.com.

CORNERSTONE CARE
COMMUNITY HEALTH CENTERS

DELTA DENTAL

Cornerstone Care Mobile Dental Program

- Signature required. Signed consent includes initial visit and 6-month checkups when appropriate.
- Treatment is limited to exams, cleanings, fluoride, x-rays, sealants, and referral when necessary.
- Please send a photocopy of your insurance card for verification of coverage and eligibility.

Health and General Information– PLEASE PRINT CLEARLY IN INK & COMPLETE ALL SECTIONS FRONT & BACK

Child's Legal Name:_______________________________ Child's Date of Birth:______________

Home Address:____
Street City Zip Code

Child's Social Security Number: ________-__________-___________ Child's Gender: M F (Circle one)

Race: ☐ White ☐ African American ☐ Asian ☐ Bi-Racial ☐ Native Hawaiian ☐ Pacific Islander ☐ American Indian

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

School: ______________________________ Teacher: ___________________ Grade: __________

Parent/Guardian Name:__________________________________ Phone Number:_______________

Parent/Guardian email address:_________________________ Parent/Guardian's Date of Birth:__________

***IMPORTANT**: List all medical conditions, medications, & allergies. Attach another page if more space is needed.

☐ Medical Conditions:_____________________________
☐ Medications:_________________________________
☐ Allergies:___________________________________
☐ Dental Issues:_______________________________

***Emergency Contact**

Contact Name:_______________________
Phone Number: ______________________
Relationship: _______________________
Primary Care Physician:_______________
PrimaryDental Provider:_______________

***Insurance Information**

I have medical insurance for my child: **Yes or No

What is the name of your child's primary medical insurance company? ____________________

ID Number:_________________________________

Date of child's last dental visit:_________________

I would like my child to be a member of the kids club:
Yes No (Circle one)

Name of Dental Insurance Company:

____

ID Number:_____________________________________

Group Number:__________________________________

Name that appears on dental insurance card:

____

I would like information on obtaining insurance for my child: **Yes or No

HOUSEHOLD INCOME INFORMATION

Enter the number of dependents you claim on your income taxes below	✓ The Appropriate Income Box	Yearly Income Between	
		0	12760
		12761	17240
		17241	21720
		21721	26200
		26201	30680
		30681	35160
		35161	39640
		39641	44120

Insured Parent's Date of Birth:___________Address:_____________________________________

Social Security number of the parent on the dental insurance card:__________-___________-__________

Telephone number shown on dental insurance card:_____________________________________

Insured parent/guardian employer name:_________________________ Relationship to child:____________

Please check: ________Yes, I give permission for my child to participate in the Cornerstone Care dental program during the current school term. I understand that my child will receive a dental exam, dental cleaning, fluoride, x-rays, and sealants if recommended by the dentist.

X:____ ______________________________

Signature of Parent/Guardian **Date**

Please Fill Out Back Side

____
Name of Patient – please print

CORNERSTONE CARE

Acknowledgement of Receipt of Notice of Privacy Practices

Cornerstone Care has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement. We reserve the right to change out Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to Contact our Privacy Officer:

Mail: Cornerstone Care, Attention: Privacy Officer, 7 Glassworks Road, Greensboro, PA 15338
Telephone: (724) 943-3308 Fax: (724) 943-3310

Acknowledgement of Receipt:

I acknowledge that I have received that Notice of Privacy Practices for Cornerstone Care.

X_______________________________ _______________________
Signature of Parent/Guardian **Date**

Consent to Disclosure of Personal Health Information to your child's School District
AND
Consent to Disclosure of Personal Health Information to Cornerstone Care

I,_______________________________, give my permission to the staff of Cornerstone Care to release
(Parent/Guardian name)
information regarding my child's medical and dental care, including my medical or dental condition, test results, appointment dates/times to the child's School/School District **AND** I give my permission to the staff of the School/School District to release information regarding my child's medical and dental care, including my medical or dental condition, test results, appointment dates/times to Cornerstone Care.

X_______________________________ _______________________
Signature of Parent/Guardian **Date**

Good Faith Efforts to Obtain Acknowledgement of Receipt

I provided the above-named patient/parent/guardian with the Notice of Privacy Practices.
Describe how notice was provided:
X Copy of Privacy Notice enclosed in Cornerstone Care Mobile Dental Program Parent Consent Sheet

Describe efforts to obtain signature on acknowledgement of notice form:
☐ Parent/Guardian was asked to sign form and refused, returned form unsigned

_______________________________ _______________________
Cornerstone Care Mobile Unit Outreach Specialist Date

Questions or Concerns

Contact: Cornerstone Care Outreach Department
Telephone: (724)-852-1001