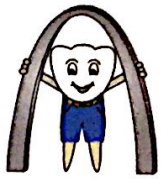
IN SCHOOL DENTAL CARE



Please complete sign & return to school. Questions? Please call (314) 872-3930

Taking care of your child's teeth is important to keep them healthy.

CHILD

1. TELL US ABOUT YOUR CHILD

☐ To decline services, check here and complete "Student Name & "Birth Date" only.

Student Name_____ Male/ Female
(PLEASE PRINT CLEARLY) FIRST NAME LAST NAME CIRCLE ONE

Student Birth Date_____/_____/_____ Race_____ School_____
MM/DD/YY (OPTIONAL)

Teacher_____ District_____ Grade_____ Room#_____

Your Name_____ Relation to Student ☐ Custodial parent ☐ Legal guardian
CHECK ONE

Address_____ City_____ State_____ Zip_____

Email_____ Phone( )_____ 2nd Phone( )_____

2. CHILD'S MEDICAL HISTORY

CHECK EACH CONDITION THAT APPLIES TO YOUR CHILD

Recent Dental Problems	Sickle Cell Anemia
Latex Allergy	Anemia/Fainting
Allergy to Medications/Other	Epilepsy/Seizures
Asthma or Wheezing	Liver Problems/Hepatitis
Behavioral Problems	Kidney Problems
Heart Problems/Murmur	HIV/AIDS
Rheumatic Fever	Cancer
Diabetes	Tuberculosis
Hemophilia/Bleeding Problems	Communicable Diseases

Notify us of any medical history changes. A thorough complete medical and dental history are important for a proper dental examination and evaluation.

List allergies_____

Name/phone # of child's physician_____

Use space below to provide additional details on your child's health, including current medical treatment, other significant past illnesses, alcohol & tobacco use (including smokeless). List current medications. Attach another page as needed.

_____

Approx. date of last dental visit._____

INSURANCE

3. DENTAL INSURANCE INFORMATION CHECK ONE

Medicaid covers 100% of Treatment

☐ **CHILD HAS MEDICAID** Circle one of the following: Missouri Medicaid (MO HealthNet), Aetna Better Health, Missouri Care, Dental Health & Wellness

Enter Child's 8-Digit ID Number HERE: ☐☐☐☐☐☐☐☐

☐ **CHILD HAS PRIVATE DENTAL INSURANCE**

ID#_____ Group #_____

Name of Plan_____ Name of Insured Parent_____ Parent DOB_____

Parent SSN_____ Employer_____

Work Phone_____ Insurance Phone_____

☐ **CHILD IS UNINSURED**

SERVICES

4. CHECK TOTAL CARE OR PREVENTIVE CARE (Check only one)

Total Care

☐ I understand and give consent to Gateway to Oral Health Foundation affiliated general dentists to provide dental care & oral hygiene instructions to my child which may include dental exams, x-rays, cleanings, fluoride, sealants, fillings, crowns, baby teeth root canals and removal of hopeless teeth at school without my presence unless I withdraw this consent. I agree to pay any portion of the charges not covered by insurance.

Preventive Care only

☐ I understand and give consent to Gateway to Oral Health Foundation affiliated general dentists to provide dental care & oral hygiene instructions to my child which will ONLY include dental exams, x-rays, cleanings, fluoride, sealants at school without my presence unless I withdraw this consent. I understand my child will not receive any needed fillings, crowns, baby teeth root canals or removal of hopeless teeth. I authorize and direct Gateway to Oral Health Foundation to bill and collect payment from any Medicaid, Insurance, or other third party payer that covers the services provided to this patient, which may be conducted by your insurance carrier and other governing bodies. I agree to pay any portion of the charges not covered by insurance.

Photographs may also be taken and used as an educational/marketing tool for our program. Once signed, this consent form is valid for the entire school year.

SIGN HERE _____ _____
DATE

Print name_____ **FOR YOUR PRIVACY PLEASE FOLD & SECURE**

Gateway To Oral Health Foundation

Notice of Privacy Practices

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. By signing the front of this form acknowledges that you have read and have agreed to our notice of privacy practices.** The privacy of your medical information is important to us.

Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect.

From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations.

Authorizations. We will not use or disclose your medical information for any reason except those described in the Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment of the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X rays, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care.

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

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

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

Your Individual Rights

Access and Copies. You have the right to review or request copies in writing to our Privacy Officer. Please contact our Privacy Officer at 2211 Olive Street, Suite 300, St. Louis, MO 63103.

Additional Restrictions. You have the right to request that we place additional restrictions on our uses or disclosures of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Complaints

If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer.
We support your right to protect the privacy of your medical 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 Us

HIPPA Officer – 2211 Olive Street, Suite 300, St. Louis, MO 63103. (314) 872-3930 or www.gtohfoundation.org

The undersigned patient or legally authorized representative ("Agent") of the Patient acknowledges that they