Portable Dental Services
Coming to Your Child’s School!!

No need for you to miss work or for your child to miss school.
Services provided on site during the school day.

If you would like your child to participate in the program
make sure you completely fill out the registration packet, sign and return to your child’s teacher.

Services we can provide:

- Dental Screening
- Oral Health Education
- Oral Exam by a Dentist
- Dental Cleanings
- Check-up X-Rays
  (2-4 x-rays that determine if there are cavities in between the teeth or under existing fillings that cannot be seen visually)
- Fluoride Treatments
  (Up to 2 times per school year and will be applied every 3 months during the school year for students ages 6 and younger)
- Dental Sealant(s)
  (A thin material applied to the pits and grooves on the chewing surface of the adult molars that help to protect the teeth from cavities)

Referrals if Needed

Questions please call: (585) 243-7847
Student’s Name: _____________________________ Date of Birth: __ __ / __ __ / __ __ __ __ □ Male □ Female

School: _____________________________ Grade: __________ Teacher: __________

☐ My child has NEVER seen a dentist

☐ My child’s dentist is:

Dentist Name: _____________________________ Phone: __ __ __ - __ __ __ - __ __ __ __

Address: _____________________________________________________________________

Has your child seen the dentist in school before? ☐ YES ☐ NO

*Please note: Your child’s dentist will be notified of the dental services provided through his/her participation in the dental program.

Race/Ethnicity (for tracking purposes only) check below:

☐ White/Caucasian ☐ Black/African American ☐ Native American

☐ Other Pacific Islander ☐ Asian

☐ Non-Hispanic ☐ Hispanic

Student’s Primary Language: ____________________

Does the student need an interpreter? ☐ YES ☐ NO

Consent to Participate

☐ YES, I give permission for my child to participate in the program (Please sign below and complete the entire packet and return in the attached envelope)

☐ NO, I do not give permission for my child to participate in the program (Please sign below and STOP)

___________________________________________  ______________________________________
Signature of Parent or Legal Guardian  Printed Name of Parent or Legal Guardian

___________________________________________  ______________________________________
Relationship to the Child  Today’s Date

If you require assistance with completion of this form or have any questions, please call (585) 243-7840 ext. 7604
Student’s Name: _____________________________ Date of Birth: __ __ / __ __ / __ __ __ __ □ Male □ Female

Address: _____________________________________ City: __________________ State: ________ Zip: _______

Social Security Number: __ __ __ - __ __ - __ __ __ __ Phone #: __ __ __ - __ __ __ - __ __ __ __

School: _________________________________________ Grade: ___________ Teacher: ___________________

Services: (Current School Year Only)

Students enrolled in this program will receive free education and a dental screening

Please CHECK below for additional services you are choosing for your child:

☐ Cleaning with a fluoride treatment (may be up to 2 times per school year, additional fluoride will be applied every 3 months during the school year for students ages 6 and younger)  x-rays , as needed , by a hygienist followed by an exam by a dentist, and dental sealants if needed (see cover letter for description)

We will provide dental service(s) without you being present.
If you wish to join your child during their dental visit, please check mark the box and we will contact you for an appointment time. If you are unreachable your child will be seen without you.

Parent/Guardian Information

Mother’s Name: _______________________________________ Email: _________________________________
Phone #: (H) __ __ __- __ __ __- __ __ __ (C) __ __ __- __ __ __- __ __ __ (W ) __ __ __- __ __ __- __ __ __-

Father’s Name: _______________________________________ Email: _________________________________
Phone #: (H) __ __ __- __ __ __- __ __ __ (C) __ __ __- __ __ __- __ __ __ (W ) __ __ __- __ __ __- __ __ __-

Guardian’s Name: _____________________________________ Email: _________________________________
Phone #: (H) __ __ __- __ __ __- __ __ __ (C) __ __ __- __ __ __- __ __ __ (W ) __ __ __- __ __ __- __ __ __-

Emergency Contact Information

(Please list someone other than the parent/guardian)
Contact Person’s Name: _____________________________ Relationship to child: __________________
Phone #: (H) __ __ __- __ __ __- __ __ __ (C) __ __ __- __ __ __- __ __ __ (W ) __ __ __- __ __ __- __ __ __-
Address: _____________________________________ City: __________________ State: ________ Zip: _______

If you require assistance with completion of this form or have any questions, please call (585) 243-7840 ext. 7604
Financial

In order for Mosaic Health to help patients without insurance coverage we must ask you to complete the following information. This is requested of you so Mosaic Health can receive Federal grant dollars to serve those patients. We appreciate your cooperation. All information is kept confidential and is used for reporting purposes only.

Total Number of people in your household (include everyone): __________

Total Household income: (Please check the amount that best describes the total income in your household)

☐ Less than $11,000  ☐ $30,001-$35,000  ☐ $55,001-$60,000
☐ $11,001-$15,000  ☐ $35,001-$40,000  ☐ $60,001-$65,000
☐ $15,001-$20,000  ☐ $40,001-$45,000  ☐ $65,001-$70,000
☐ $20,001-$25,000  ☐ $45,001-$50,000  ☐ $70,001-$75,000
☐ $25,001-$30,000  ☐ $50,001-$55,000
☐ Greater than $75,000

Financial Assistance: Based on the information in household income above, you and your family may be eligible for Mosaic Health’s Sliding Fee Scale Discount Program. A staff member may be contacting you for follow-up.

Dental Insurance Information

☐ UNINSURED for DENTAL COVERAGE

☐ MEDICAID INSURANCE ID# __ __ __ __ __ __ __ __ __ __ __ __
(2 letters, 5#'s, 1 letter-ex. AB12345C)

☐ OTHER DENTAL INSURANCE ID# __ __ __ __ __ __ __ __ __
GROUP# __ __ __ __ __ __
PLAN NAME: __________________________INSURANCE PHONE#:_________________________
INSURANCE COMPANY STREET ADDRESS:______________________________________________
POLICY HOLDER NAME: ____________________________DOB: ___ / ___ / ___ ___
SOCIAL SECURITY NUMBER: ___-___-_______EMPLOYER: ____________________________

Responsible Party

Name: ___________________________________________Date of Birth: ___ / ___ / ___ ___
Phone #: __ __ __-_______City: ____________________State: _____________Zip: __________
Social Security Number: ___-___-_______
Address: ________________________________________Relationship to Child: __________________

If you require assistance with completion of this form or have any questions, please call (585) 243-7840 ext. 7604
Does Your Child Currently Have or Has Previously Had Any of the Following Medical Conditions?

(Please circle YES or NO for each condition listed)

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>ADHD/ADD</td>
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<tr>
<td>Allergy to Latex</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Artificial Joints</td>
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<tr>
<td>Asthma</td>
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<td>Autism</td>
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<td>Blood Disorder/Anemia</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Heart Trouble (murmur, prosthesis)</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Kidney Disease or Trouble</td>
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<tr>
<td>Low Blood Pressure</td>
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<td>Pregnancy (Due Date:___________)</td>
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<tr>
<td>Seizures or Epilepsy</td>
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<td>Tuberculosis (TB)</td>
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<tr>
<td>Other: _________________________</td>
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</tbody>
</table>

If Yes to any question above, please explain: _______________________________________________________
___________________________________________________________________________________________

Does your child have any allergies?  □ YES  □ NO

Please List Allergies: _______________________________________________________________________

Has your child had any major surgeries?  □ YES  □ NO

Please List Types and Dates: ________________________________________________________________

Has your child had any overnight hospitalizations in the past 3 years?  □ YES  □ NO

Please List Reason and Dates: ________________________________________________________________

Does your child take any medications on a DAILY basis?  □ YES  □ NO

Please List Medications/Dosage: ______________________________________________________________
______________________________________________________________________________

Do you have any concerns regarding your child’s dental health?  □ YES  □ NO

Please explain: _______________________________________________________________________

What is the source of your child’s water?  □ Town/City  □ Bottled  □ Well

Medical Provider Information

Does your child have a Medical Provider (Doctor, Nurse Practitioner, or Physician Assistant)?  □ YES  □ NO

Name of Provider: ____________________________________________ Phone # __ __ __-__ __ __-__ __ __

Address: _______________________________________City:________________ State: _______ Zip: _________

Pharmacy Information

Name of Pharmacy: ___________________________________________ Phone #: __ __ __-__ __ __-__ __ __

Address/Location: _______________________________________City:________________________Zip:____________

If you require assistance with completion of this form or have any questions, please call (585) 243-7840 ext. 7604
CONSENT
In order for us to treat your child, you must sign below indicating you have read and agree to the following information:

Authorization for Treatment:
I, the undersigned, the parent or legal guardian of the above named child, hereby authorizes the dental staff of Mosaic Health to provide dental care as indicated to my child in his/her school. It is the parent/guardian(s) responsibility to inform the dental provider of any changes in their child’s medical information by calling (585) 325-2280 Extension 7604.

Financial Responsibility/Assignment of Benefits:
I authorize Mosaic Health to apply for benefits on my behalf to my child’s insurance carrier and request my child’s insurance company pay directly to Mosaic Health. insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify Mosaic Health of any changes. If your child has had a dental cleaning within the past 6 months and you have used your insurance, he/she is not eligible for insurance reimbursement at this time. If your insurance covers partial payment or denies services you may be billed for services. The following services and fees may be billable: dental cleaning with a fluoride treatment is $115 (ages 0-6), dental cleaning with a fluoride treatment is $97 (ages 7-12), dental cleaning with a fluoride treatment is $125 (ages 13+), pediatric exam (ages 0-3) is $73, initial dental exam is $83, recall patient exam is $47, two bitewing radiographs are $44, four bitewing radiographs are $63, a single radiograph is $27 and sealants are $52 per tooth. No child will be denied services due to inability to pay, please call for assistance.

Release of Information:
If my child’s health history indicates health problems which may affect his/her dental treatment or if proof of legal guardianship is needed, I consent to having my child’s medical doctor/dentist/school release my child’s medical/dental/guardianship information to the Mosaic Health dental staff. If a dentist is noted above, I understand that any dental findings/treatment shall be forwarded to that provider. I also give consent for Mosaic Health to provide my child’s school nurse with a dental health certificate, if requested.

***Forms that do not have a parent/guardian’s signature will be returned***

Childs Name: ________________________________  Date of Birth: __ __ / __ __ / __ __ __ __

________________________  __________________________
Signature of Parent or Legal Guardian  Printed Name of Parent or Legal Guardian

________________________  __________________________
Relationship to the Child  Today’s Date

If you require assistance with completion of this form or have any questions, please call (585) 243-7840 ext. 7604