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.

Services we can provide:
- Dental Screenings
- Oral Health Education
- Oral Exam by a Dentist
- Dental Cleanings
- Checkup 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
  (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

Please see attached form for more information
If you would like your child to participate in the program make sure the form is completely filled out front to back.

Questions please call: (315) 570-4020
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 (315) 570-4020
Student’s Name: _____________________________ Date of Birth: ____ / ____ / ______  □ Male □ Female

Address: ____________________________ City: __________________ State: ______ Zip: _______

Social Security Number: ______ - ______ - ______ Phone #: ______ - ______ - ______

School: ____________________________ Grade: ______ Teacher: ___________________

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**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** by a hygienist followed by an **exam** by a dentist, and **dental sealants** if needed (see cover letter for description)

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**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) ______ - ______ - ______

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**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: _________

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If you require assistance with completion of this form or have any questions, please call **(315) 570-4020**
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 that 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
- $11,001-$15,000
- $15,001-$20,000
- $20,001-$25,000
- $25,001-$30,000
- $30,001-$35,000
- $35,001-$40,000
- $40,001-$45,000
- $45,001-$50,000
- $50,001-$55,000
- $55,001-$60,000
- $60,001-$65,000
- $65,001-$70,000
- $70,001-$75,000
- 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

PLAN NAME: __________________________ INSURANCE PHONE#: __________________________

INSURANCE COMPANY STREET ADDRESS: ________________________________________________

POLICY HOLDER NAME: ___________________________ DOB: __ / __ / __

SOCIAL SECURITY NUMBER: ___ ___ - ___ - ___ ___ ___ ___ EMPLOYER: ___________________

Responsible Party

Name: ___________________________________________ Date of Birth: __ / __ / ___

Phone #: ___ ___ - ___ - ___ - ___ ___ Social Security Number: ___ ___ - ___ - ___ ___ ___ ___

Address: ______________________________________ City: __________________________ State: ______ Zip: ______

Relationship to Child: ____________________________________________

If you require assistance with completion of this form or have any questions, please call (315) 570-4020
Does Your Child Currently Have or Has Previously Had Any of the Following Medical Conditions?

(Please circle YES or NO)

<table>
<thead>
<tr>
<th>Medical 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>
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<td>Artificial Joints</td>
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<td>Asthma</td>
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<td>Autism</td>
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<td>Blood Disorder/Anemia</td>
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<td>Cancer</td>
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<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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<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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<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 (315) 570-4020
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 (315) 570-4020.

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 (315) 570-4020