mosaic health
Community Dentistry

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**

mosaic health
Community Dentistry

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: _____

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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
- ☐ $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$75,001

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 INSURACE 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 #: __ __ __-__ __ __-__ __ __ __ Social Security Number: __ __ __ - __ __ - __ __ __ __

Address: _____City:_____State:_____Zip:_____

Relationship to Child: _____

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Does Your Child Currently Have or Has Previously Had Any of the Following Medical Conditions?

(Please circle YES or NO for each condition listed)

ADHD/ADD	YES	NO	Heart Trouble (murmur, prosthesis)	YES	NO
Allergy to Latex	YES	NO	High Blood Pressure	YES	NO
Artificial Joints	YES	NO	Kidney Disease or Trouble	YES	NO
Asthma	YES	NO	Low Blood Pressure	YES	NO
Autism	YES	NO	Pregnancy (Due Date:_____)	YES	NO
Blood Disorder/Anemia	YES	NO	Seizures or Epilepsy	YES	NO
Cancer	YES	NO	Tuberculosis (TB)	YES	NO
Diabetes	YES	NO	Other: _____	YES	NO

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

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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**

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Community Dentistry

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.

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**