Dental Outreach Program

WELCOME

You have been invited to participate in our Dental Outreach Program and we are excited to see you! We will provide the AAPD and ADA recommended oral health screenings and preventative dental treatment which should be performed every 6 months. Should you have additional treatment needs, we may contact you with that information and help coordinate an in-office appointment with you. Please help us as we gather some additional information about you. *We take most insurance and AHCCCS plans, if you have no insurance – it is not a problem!* If you have any questions, contact us at (806) 292-9115, or email alyssa@thesmilezone.org or supersmilesforkids@gmail.com. Thank you for trusting us with your dental care. We promise to do our best to provide the finest care available.

PATIENT INFORMATION

Name _____

Birthdate _____ Home/ Cell _____ **May we text you?** □ **YES** □ **NO**

Address _____ City _____ State _____ Zip _____

□ Married □ Single □ Child □Other _____ Email _____

EMERGENCY CONTACT

Name _____ Home/ Cell _____

IF PATIENT IS A CHILD UNDER THE AGE OF 18, PARENT/ GUARDIAN PLEASE FILL OUT BELOW:

Parent/ Guardian Name _____

Birthdate _____Home/ Cell _____ **May we text you?** □ **YES** □ **NO**

□ Married □ Single □ Other _____ Email _____

INSURANCE INFORMATION – PRIMARY

Insurance Plan Name _____ Insurance Phone _____

Insurance ID #_____ Insurance Group # _____

Name of Policy Holder _____ Relation to Patient _____

Policy Holder Date of Birth _____ SS# _____ Home/ Cell _____

Employer Name _____ Employer Phone # _____

INSURANCE INFORMATION – SECONDARY

Insurance Plan Name _____ Insurance Phone _____

Insurance ID #_____ Insurance Group # _____

Name of Policy Holder _____ Relation to Patient _____

Policy Holder Date of Birth _____ SS# _____ Home/ Cell _____

Employer Name _____ Employer Phone # _____

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STUDENT INFORMATION

Student Full Name _____ Date of Birth _____

School _____ Teacher Name _____ Grade _____

Parent/ Legal Guardian _____ Cell/ Home Phone # _____

(Please Print Full Name)

May we text you? □ **YES** □ **NO**

DENTAL HISTORY

Male □ **Female** □

Has your child been to a dentist in the last 6 months? □ No □ Yes

Check if your child has or has had problems with any of the following:

- □ Bad Breath
- □ Bleeding Gums
- □ Clicking or popping jaw
- □ Food collection between teeth
- □ Grinding Teeth
- □ Loose teeth or broken fillings
- □ Periodontal treatment
- □ Sensitivity to cold
- □ Sensitivity to hot
- □ Sensitivity to sweets
- □ Sensitivity when biting
- □ Sores or growths in the mouth

MEDICAL HISTORY

Has your child recently had any serious illnesses or operations? □ No □ Yes: _____

Has or is your child taking any weight loss drugs? □ No □ Yes: _____

Please check if you have or have had problems with any of the following:

- □ Anemia
- □ ADD/ ADHD
- □ Arthritis, Rheumatism
- □ Artificial Heart Valves
- □ Artificial Joints, Pins, Etc.
- □ Asthma
- □ AUTISM
- □ Back problems
- □ Bleeding abnormally
- □ Blood disease
- □ Cancer
- □ Chemical Dependency
- □ Chemotherapy
- □ Circulatory Problems
- □ Congenital Heart lesions
- □ Cortisone Treatments
- □ Cough, Persistent
- □ Cough up Blood
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Headaches
- □ Heart Murmur/ Pre-Med?_____
- □ Heart Problems
- □ Hemophilla
- □ Hernia Repair
- □ High Blood Pressure
- □ HIV/AIDS
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Radiation Treatment
- □ Respiratory Disease
- □ Rheumatic fever
- □ Scarlet Fever
- □ Shortness of Breath
- □ Skin Rash
- □ Stroke
- □ Swelling of Feet or Ankles
- □ Thyroid Problems
- □ Tobacco Habit
- □ Tuberculosis
- □ Ulcer
- □ Venereal Disease

Does your child have any syndromes or medical conditions? _____

List medications you are currently taking: _____

_____

ALLERGIES:

- □ ASPIRIN
- □ Barbiturates (Sleeping Pills)
- □ CODEINE
- □ Local Anesthetic
- □ PENICILLIN
- □ SULFA
- □ Iodine
- □ LATEX
- □ None
- □ Other _____ _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my minor child's school nurse and/ or dental provider if they have any changes in health so that the provider is informed. I give consent to any preventive dental treatment needed for my child including an exam evaluation, screening, x-rays, cleaning, fluoride, SDF and *if needed* sealant or protective restoration treatment. I further give consent to bill my dental insurance, if applicable. By signing below, I also acknowledge that I have received a copy of the Notice of Privacy Practice

_____ _____

SIGNATURE (Parent/ Legal Guardian - Listed Above) Date

FOR QUESTIONS, DENTAL RECORDS OR ADDITIONAL INFORMATION REGARDING YOUR CHILDS VISIT YOU MAY EMAIL: alyssa@thesmilezone.org OR supersmilesforkids@gmail.com OR CALL: (806) 292-9115

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide yo or u with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health 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: Dora Pesqueda Telephone: 806-292-9115 Email: dora@supersmilesforkids.com or TheSmileZone.DentalOutreach@gmail.com