The Dakota Smiles Mobile Dental Program is Coming to Piedmont Valley Elementary!

Your child's teeth are important. Dental disease (cavities) can threaten a child's health, well- being and achievement. Children with oral health problems can have difficulty eating and sleeping and paying attention in school.

The Dakota Smiles Mobile Dental Program includes two trucks that are fully equipped dental offices on wheels. By participating in the Dakota Smiles program, your child can receive quality oral health services, including cleanings, preventive services, fillings and oral health education.

The staff and volunteers of the Dakota Smiles program will treat children ages 0-21 who do not have a dental home (children who have not seen a dentist for two years or live more than 85 miles from a dentist). No child will be turned away for inability to pay.

Dakota Smiles Schedule

Time: February 8-12, 2016
Location: Piedmont Valley Elementary School
For more information call: School Nurses' Office at 347-2610

- -

I am interested in having my child participate in the Dakota Smiles program and understand that I will need to sign additional authorization forms before my child can obtain services.

Child's Name (please print) ____

Parent/legal guardian signature ____

Age_____ Grade_____ Date_________ Parent Phone Number____________________

Teacher____

PLEASE RETURN THIS SLIP TO <u>School Nurses Office</u> BY <u>January 13, 2016</u>

Piedmont Valley Elementary School
16159 Second Street
Piedmont Valley SD 57769

Delta Dental Mobile Dental Programs
Patient Information Form

A

Please fill out this form completely. If you have questions, please ask a Dakota Smiles staff member. Thank You!

Patient's Legal Name _____ **Birth Date** (mm/dd/yyyy) _____

Patient's Social Security Number _____ - _____ - _____

School Attending _____ **Grade** _____ **Age** _____ **Sex** (circle) M F

Ethnicity: (circle) *White* *Black or African American* *Asian* *American Indian* *Hispanic/Latino* *Other*

Home Address _____
Street/ P.O. Box City State Zip

Phone Numbers: Home (_____) _____ Work (_____) _____

Cell (_____) _____

Parent/Guardian Name _____

Note: Dental visits should start at age 1.

Emergency Contact: Person to contact in case of an emergency

Name _____ Relation to patient _____ Phone (____) _____

Income: Which of these best represents your annual household income? (circle one)

Less than $10,000 *$10,000-20,000* *$20,000-30,000* *More than $30,000*

Household Size: How many children less than 21 years of age live in your household? _____

Dental History	Yes	No	
Is this the patient's first dental visit? Past or current dentist name_____			If no, how long has it been? (√) ___less than 13 months ___less than 2 years ___more than 2 years
Does the patient brush daily?			
Does the patient floss?			
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?			
Does the patient drink milk daily?			
Has dental pain caused you or your child to miss school and/or work in the last year?			If "yes", circle – school work both How many times?
Has the patient visited the ER/hospital for dental pain in the last year?			If "yes", how many times?

Medical History	Yes	No	Please Explain "yes" Answers
Patient's current physician _____ Date of last medical exam (mm/yy) _____			
Does the patient have a current medical condition?			
Is the patient taking any medications?			
Has the patient ever been hospitalized or had surgery?			
Does the patient have any allergies?			
Is the patient current on immunizations?			
Does the patient have any special needs that would require special arrangements for dental care? i.e. autism			

Reason for Visit: Check any that apply (√)

☐ First examination ☐ Couldn't afford dental care ☐ Couldn't get appointment anywhere else

☐ Toothache/mouth pain/face swelling ☐ Other (specify)_____

Has the patient had a history of or had difficulty with the following? Check any that apply (√)

☐ Latex allergy	☐ Asthma	☐ Diabetes	☐ Liver disease
☐ AIDS / HIV	☐ Birth defects	☐ Fainting	☐ Mono
☐ Epilepsy/ seizures	☐ Cancer	☐ Heart problems	☐ Rheumatic fever
☐ Excessive bleeding	☐ Cerebral Palsy	☐ Hepatitis	☐ Tuberculosis
☐ Anemia	☐ Convulsions	☐ Kidney disease	☐ Other _____

Please explain "yes" answers: _____

Behavioral Issues	Yes	No	
Is the patient using tobacco products (cigarettes, chewing tobacco)?			
Does anyone smoke in the household?			
Is the patient using alcohol and/or drugs?			

Insurance: Please circle any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided. **MUST PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD IF APPLICABLE.**

Medicaid/ SCHIP **Private DENTAL Insurance** (please provide copy of card) **IHS** **None**

Medicaid Number/ Policy Number _____ Reservation (IHS) _____

Dental Ins. Name: _____ policy #_____ group # _____

Dental Ins. Address: _____ Ins. Phone # _____

Employer Name: _____

B

Treatment Consent and Agreement

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print child's name)

give my consent for the dental services I have authorized below. I understand there may be risks involved with dental treatment. Each item needs to be answered in order to receive dental care.

Yes	No	
		Preventive Services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment. (Circle of Smiles provides preventive services only)
		Dentist Exam (including dental x-rays)
		Restorative Services: fillings, stainless steel crowns, pulpotomy. Anesthesia is used for these procedures.
		Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Anesthesia is used for these procedures.
		I have received and/or read a copy of the Delta Dental's HIPAA Notice of Privacy Practices
		I consent to share my or my child's health care records with other health care providers or agencies as needed.
		I consent to the use of pictures, video or audio recordings of myself or my child for program promotion.

Parent/Legal Guardian signature _____ Date _____

Dakota Smiles Mobile Dental Program

804 N. Euclid, Ste. 101. Pierre, South Dakota, 57501

Patient Rights and Information

Each patient shall have the right to:

1. Be treated with respect and dignity
2. Treatment which is free of discrimination on the basis of race or religion and is performed according to individualized needs
3. Safe and efficient treatment
4. Voice their personal feelings via verbal or written means
5. Information concerning their diagnosis, and planned treatment for their dental needs
6. Obtain information as to any relationships this facility has with other professional individuals or medical facilities, in so far as their care is concerned
7. Expect confidentiality in communications and records pertaining to their dental treatments
8. The information necessary to give informed consent to treatment

Patient Responsibilities

Each patient /parent shall be responsible for the following:

1. Providing accurate and complete information for use in notification of dental needs and appointments
2. Provide child's immunization record.
3. Keeping appointments and notifying Dakota Smiles staff if unable to do so
4. Asking questions when he or she does not understand something
5. Being respectful and considerate of all staff and other patients being treated by the Dakota Smiles Mobile Dental Program.
6. For their own actions should they refuse treatment or for not following instructions given to them by the dental staff
7. To provide responsible transportation and assistance if needed
8. To follow all Dakota Smiles policies and procedures

Patient Risks

The risks of dental procedures are usually minimal. Risks may include reaction to anesthesia, bleeding, and infection. The Dakota Smiles Mobile Dental Program uses digital x-ray equipment. Digital x-ray equipment significantly reduces radiation exposure (as compared to traditional x-ray equipment). If there are additional potential risks, the treating dentist will contact the parent and/or patient. If you have further questions regarding any potential risks, please contact the Dakota Smiles staff prior to your child's visit.

Dakota Smiles Mobile Dental Program

PATIENT 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 (05/17/2004), 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 or photographs 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 you 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 may 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.

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 May 17, 2004. 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: Jeff Miller

Phone Number: 605-224-7345
Fax Number: 605-224-0909

Address: 720 N Euclid
P.O. Box 1157
Pierre, SD 57501