School-Based Dental Program Coming to your Student's School!!!!

Welcome…

Your school district/Head Start program offers an in-school portable preventative dental health program through Mosaic Health for students enrolled in participating eligible schools.

What is the School-Based Dental Program?

The portable dental program operates within the school building while the school is in session, utilizing portable dental equipment that is easily set-up and broken down. We visit the school yearly for a limited amount of time based on student enrollment.

What Services are Offered?

Preventative services offered include screenings, exams, dental x-rays, intra-oral photos, cleanings, fluoride treatments, and sealants. Additionally, age-appropriate dental education is provided in classroom sessions or virtually by video presentations. Services are provided by a New York State licensed Dental Hygienist and Dentist from Mosaic Health.

What does it cost?

No child will be denied services due to inability to pay, please call for assistance.
Mosaic Health will bill your student's dental insurance carrier directly for services. Most insurances cover preventative services at 100%.

Who is Eligible for the Program?

All students may receive preventative dental care. If you have a family dentist, your student can still get preventative care at school. We will send a letter about the services your student receives to their family dentist and provide a copy of their x-rays/intra-oral photos when requested by their dentist.

How do I Enroll My Student?

Please complete the attached ***Dental Enrollment Form*** and return to your student's school.

How are Appointments Scheduled?

Once enrollment forms have been collected and registered into the program, we will set up and start seeing students. Your student will be called down to the dental services area for their appointment which takes 20-30 minutes typically. We always try to avoid a core subject or special activity when providing services.

After the visit your student will receive a goody bag filled with oral hygiene supplies, and a letter discussing the outcome of the appointment. If there are areas of concern, a phone call to the student's home will be made.

Can I come to my student's appointment?

Parents are welcome to come, **but it is not necessary**. There is a spot on the enrollment form where you can indicate you would like to attend. We will do our best to accommodate.

Our Patient Bill of Rights & Privacy Notice can be found at: https://mosaichealth.org/forms-documents . A hard copy will be provided if requested.

It's important to keep your teeth healthy!

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Completion of Dental Enrollment Form
is Required Each School Year

For Office Use Only:
Prophy: _____
BWX: _____
Fluoride: _____
Exam: _____
Sealants: _____
Other: _____

Participation

☐ **YES,** I give permission for my student to participate in the school based dental program.
Please go to Student Information Section and complete the entire form. Return to your student's school in the attached envelope.

☐ **NO,** I do not give permission for my student to participate in the school based dental program.
Please fill in student's name, school, teacher and sign and date below.

Student's Name: _____

School: _____ Teacher/Homeroom: _____

_____ _____
Printed Name of Parent or Legal Guardian **Signature** of Parent or Legal Guardian

_____ _____
Relationship to Student Today's Date

Student Information

School: _____ Teacher/Homeroom: _____Grade: _____

Last Name: _____ First Name: _____Suffix: _____

Date of Birth: _____/_____/_____ Sex at Birth: ☐ Male ☐ Female

Social Security: _____-_____-_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ ☐ Home ☐Cell ☐Work

Phone Number: (_____) _____ ☐ Home ☐Cell ☐Work

Primary Spoken Language: _____ Interpreter Needed? ☐Yes ☐ No

Would you like to attend your student's dental appointment at school? ☐Yes ☐ No

If you marked yes, we will contact you for a date and time. **If you are unreachable your student will be seen without you.**

If you require assistance with completion of this form or have any questions, please call **(315) 570-4020**

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Parent/Legal Guardian Information

Last Name: _____ First Name: _____

Phone Number: (_____) _____ ☐ Home ☐Cell ☐Work

Phone Number: (_____) _____ ☐ Home ☐Cell ☐Work

Relationship to Student: ☐Father ☐Mother ☐ Legal Guardian- ***(please provide a copy of court order)***

Last Name: _____ First Name: _____

Phone Number: (_____) _____ ☐ Home ☐Cell ☐Work

Phone Number: (_____) _____ ☐ Home ☐Cell ☐Work

Relationship to Student: ☐Father ☐Mother ☐ Legal Guardian- ***(please provide a copy of court order)***

Responsible Party

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____

Phone Number: (_____) _____ ☐ Home ☐Cell ☐Work

Relationship to Student: ☐Father ☐Mother ☐ Legal Guardian

Street Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Information

Last Name: _____ First Name: _____

Phone Number: (_____) _____ ☐ Home ☐Cell ☐Work

Relationship to Student: ☐Father ☐Mother ☐Step- Parent ☐ Legal Guardian ☐Other: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

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As a Federally Qualified Health Center (FQHC), we can offer services to all our patients, including the underserved, because of our federal designation. As an FQHC, we are required to gather, on a yearly basis, statistics about the patients we serve. This information is confidential and will be used for statistical purposes only. We appreciate you taking time to complete all questions in this section.

Student's Sexual Orientation:

☐ Straight or Heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Do not know ☐ Choose not to disclose
☐ Something else, please describe: _____

Student's Gender Identity:

☐ Male ☐ Female ☐ Transgender Female (Male to Female) ☐ Transgender Male (Female to Male)
☐ Genderqueer, neither exclusively male nor female ☐Choose not to disclose
☐ Something else, please describe: _____

Student's Race:

☐Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan
☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ Choose not to disclose

Student's Ethnicity:

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Declined to specify

Household Information: Annual Household Income: Please check box

☐ 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

Household Size: _____
(Number of people in household this income supports)

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Insurance Coverage

☐ Student **has NO dental coverage**

☐ Student has Medicaid/Medicaid Managed Care Plan

MEDICAID # ___ ___ ___ ___ ___ ___ ___ ___
(2 letters, 5#'s, 1 letter-ex. AB12345C)

Student's DENTAL Insurance Information, if other than Medicaid:

Subscriber Name (Name on Insurance Card): _____

Subscriber DOB: _____/_____/_____

Insurance Company: _____

Subscriber ID#: _____ Group#:_____

Student's MEDICAL Insurance Information, if other than Medicaid:

Subscriber Name (Name on Insurance Card): _____

Subscriber DOB: _____/_____/_____

Insurance Company: _____

Subscriber ID#: _____ Group#:_____

Pharmacy Information

Student's Pharmacy Name: _____

Address/Location: _____

Phone Number: (_____) _____

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Medical/Dental History

Dentist:

☐ Has **NEVER** seen a dentist

☐ **CURRENT** Dentist ***(seen within the last 2 years)***:

Dentist Name:_____

Address: _____City: _____State: _____Zip Code: _____

(The above dentist <u>will be</u> notified of dental services/outcomes provided through the dental program)

Medical Provider (Doctor, Nurse Practitioner, or Physician Assistant):

☐ Does **NOT** have a Medical Provider

☐ **Has** a Medical Provider

Name of Provider: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____

<u>Does Your Student Currently Have or Has Previously Had Any of the Following Medical Conditions?</u>
(Please check all that apply)

☐ADHD	☐Autism	☐Heart Condition	☐Pregnancy
☐Allergy to Latex	☐Blood Disorder	☐High Blood Pressure	(Due Date: _____)
☐Anemia	☐Depression	☐Liver Disease	☐Seizures
☐Anxiety	☐Diabetes	☐Low Blood Pressure	☐Tuberculosis (TB)
☐Artificial Joints	☐Cancer	☐Kidney Disease	☐Other: _____
☐Asthma	☐Epilepsy	☐ODD	_____

If **YES** to any of the above medical conditions, please explain: _____

_____

Does your student <u>have any **allergies**</u>? ☐ YES ☐ NO

Please List Allergies: _____

Does your student **<u>take any medications</u>** daily? ☐ YES ☐ NO

Please List Medications: _____

Has your student had <u>any **major surgeries**</u>? ☐ YES ☐ NO

Please List Types and Dates: _____

Has your student had any **<u>overnight hospitalizations</u>** in the **<u>past 3 years</u>**? ☐ YES ☐ NO

Please List Reason and Dates: _____

Do you have any concerns regarding your <u>student's **dental health**</u>? ☐ YES ☐ NO

Please explain: _____

What is the <u>source</u> of your **<u>student's water</u>**? ☐ Town/City ☐ Bottled ☐ Well

If you require assistance with completion of this form or have any questions, please call **(315) 570-4020**

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Consent:
In order to treat the student, **you must sign and date below** indicating you have read and agree to the following information:

I authorize my student to receive services provided by the staff of Mosaic Health. Services may include: a **dental screening**, **dental exam** (may be virtual), **intra oral photos**, **x-rays**, **dental cleaning with fluoride application** and **dental sealants** *(additional fluoride application will be applied every 3 months during the school year for students ages 6 and younger).*

Authorization for Treatment:
I, the undersigned, the parent or legal guardian of the above-named student, hereby authorizes the dental staff of Mosaic Health to provide dental care as indicated to my student in their school. ***It is the parent/guardian(s) responsibility to inform the dental provider of any significant changes in their student's medical information by calling (315) 570-4020.***

Financial Responsibility/Assignment of Benefits:
I authorize Mosaic Health, Inc. to apply for benefits on my/my student's behalf to my insurance carrier and request my insurance company pay directly to Mosaic Health, Inc. 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 student has had a dental cleaning within the past 6 months and you have used your insurance, they are not eligible for insurance reimbursement at this time.*** If your insurance covers partial payment or denies services, you may be billed for services. ***No child will be denied services due to inability to pay, please call for assistance.***

Service/Fees:
Dental Cleaning (Ages 0-12): $65.00
Dental Cleaning (Ages 13+): $109.00
Sealants per tooth: $52.00
Fluoride Treatment: $54.00

Dental X-rays:
2 BWX-$44.00, 4 BWX-$63.00,
PA-$27.00 ea. Additional $24.00
Exam:
New Patient: $83.00, Established Patient: $58.00

Release of Information:
If my student's health history indicates health problems which may affect their dental treatment or if proof of legal guardianship is needed, I consent to having my student's medical doctor/dentist/school release my student'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 student's school nurse/ Head Start designee with a dental health certificate, if requested.

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

Students Name: _____ Date of Birth: _____/_____/_____

_____ _____
Signature of Parent or Legal Guardian **Printed Name** of Parent or Legal Guardian

_____ _____
Relationship to the Student **Today's Date**

If you require assistance with completion of this form or have any questions, please call **(315) 570-4020**