2014/2015 School Year:

New form needed EACH year!

a North Country Health Consortium program

The Molar Express is a mobile dental clinic that is equipped to provide services typically found in any general dental practice. Our services include: Exams, Cleanings, X-rays, Fillings, Extractions, etc.

We will be offering School-Based Clinics. Students receive dental care without having to miss a day of school!

REGISTRATION FORM

Please return this form to your school nurse!

A new form must be filled out each school year for each child.

Is The Molar Express for my child?

The Molar Express program is for children who **do not** have a dental care home (regular dentist) **or** who are not able to get dental care because they are on NH Medicaid **or** cannot get to a dentist for other reasons. At this time, these services are provided at no cost to you.

Our contact information:

- Go to our website: www.nchcnh.org (click on the truck!)
- Call us at (603) 259-3700
- Check out our Facebook Page at The Molar Express
- Email us a request at molarexpress@nchcnh.org
- Address: The Molar Express, 262 Cottage St. Suite 230 Littleton, NH 03561

We look forward to seeing your child's smile soon!

The Molar Express

Patient's Rights and Privacy Practices Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully**.

Uses of Information and How Information is Disclosed

Information given to The Molar Express and its staff may be used for treatment, including for: 1) identifying treatment goals agreed upon by both patient and staff; 2) setting a plan of treatment for pursuing those goals; and 3) monitoring effectiveness of the treatment plan. An example of each of these would be: the Dentist suggests a treatment plan for the patient and the patient and Dentist (or the Dentist's representative) talk about the treatment plan and agree on the services to be provided.

Information given to The Molar Express and its staff may be used as The Molar Express and/or its agents seek payment for services, including: 1) mailing invoices to a patient at the address given by the patient; 2) submitting patient information to insurance providers, if the patient requests this, such as social security number, date of birth, address, dental diagnosis, insurance policy number, and dates of service; 3) writing, phoning, or e-mailing the other payer(s), if the patient requests this, and identifying the patient, to seek payment for services; and 4) giving patient information such as social security number, date of birth, address, and dates of service to a collections agency if the patient makes no payment arrangements as per the payment agreement.

Information given to The Molar Express and its staff may be used by The Molar Express and/or its agents for dental care operations, in the sense that staff will track appointment times and will write in patient chart information about dental diagnosis and treatment services provided. Staff may telephone the patient with appointment reminders and other treatment related information.

Information will be disclosed generally by providing hand delivered materials in sealed envelopes, via United States mail or by talking on the phone, when disclosure is appropriate. However, with a few exceptions (see below), information about a patient will not be disclosed to anyone outside of The Molar Express without the patient's written authorization. The patient may revoke such authorization at any time; revoking authorization requires two actions by the patient: 1) telling or writing such to staff; and 2) ensuring that their request has been received by staff, by for instance asking staff to state understanding that authorization is revoked.

Without the patient's written authorization, information about a patient will not be disclosed to anyone, with the following exceptions: 1) if staff determines that the patient or someone else is at risk of eminent physical harm; 2) if staff determines that a child, (meaning anyone under 18 years old) might have been or possibly is being physically harmed, neglected or endangered; 3) if staff determines that a senior (meaning anyone 60 years old or older) might have been or possibly is being physically harmed, neglected or endangered; 4) if there is a medical emergency; or 5) if ordered by a judge. In such situations, staff will provide information deemed useful to ensure safety or to abide by applicable law and may take steps to ensure safety, including for example calling police or arranging a hospital visit.

Patient's Rights

A The Molar Express patient has the right to: 1) request restrictions on certain uses and disclosures of protected health information, although The Molar Express is not required to agree to the request; 2) receive confidential communications of the patient's protected health information; 3) inspect and copy protected health information; 4) request to amend protected health information; 5) receive an accounting of disclosures of protected health information; and 6) receive a copy of this notice upon request.

Responsibilities of The Molar Express

The Molar Express is required by law to: 1) maintain the privacy of protected health information and to provide patients with notice of this responsibility; and 2) follow the terms of this notice whenever transmitting patient information by computer and 3) offer patients a revised copy of this notice if The Molar Express revises this notice in the future.

Complaints

If you believe your privacy rights have not been upheld, you may inform The Molar Express and its staff at 603 259-3700. The best approach for addressing such complaints would be to discuss it with The Molar Express staff. If after doing this you are not satisfied, you may call the HIPAA Hotline at 866-627-7748 or www.cms.hhs.gov/hipaa.

The Molar Express

REGISTRATION FORM

Patient Information

In order for your child to receive dental cleanings (polishing), fluoride treatments, preventive and restorative dental care at school, please complete both sides of this confidential form, sign and return to your child's school nurse.

Child and Parent Information

Child's name _____________________________________ Social Security #: -- --

Date of Birth ______________ Age ______Sex (M) or (F) Grade _____________ Teacher _________________

School ____

Home Address ____Town_____________________________

Parent or Guardian Name ____________________________________ Phone (Work) _______________________

Phone (home) _________________________ Phone (cell)__________________ Do you accept texts? _________

Email address____

(Phone contact information is required so the Dental Team may talk to you about your child.)

Child's Dental History

___ My child does **not** have a regular dentist. (If yes, see below)

Date child was last seen by a dentist? ________________ Why?_______________________________

Any information you want us to know about your child's dental needs?___________________________

____

___ **My child has a regular dentist.**

Regular Dentist's Name _______________________________________ Dentist's Phone ___________

Date child was last seen by Dentist __________________ Reason seen __________________________

Date child last had their teeth cleaned _______________ Does your child take fluoride tablets? _______

Has your child had fluoride treatments? _____________ Any adverse reaction to fluoride? ___________

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _______________________________ Phone: (____) _______________________

Group/Policy #:____________________

Insured's Name: ____ Insured's Birth date: ___/___/___

Relation: __________________

Insured's Social Security #: ________________________ Insured's Employer: ____________________

Does your child have NH Medicaid Insurance (formerly Healthy Kids)? YES NO

If Yes: NH Medicaid Number (ID # at the bottom of the card): _______________________________________

_________ CHECK HERE IF YOU DO NOT HAVE ANY TYPE OF DENTAL OR MEDICAID INSURANCE

The Molar Express program is for children who **do not** have a dental care home (regular dentist) **or** who are not able to get dental care because they are on NH Medicaid **or** cannot get to a dentist for other reasons.

Please remember children who already have a dental care home (regular dentist) are not eligible for the Molar Express. We appreciate your understanding. If you have any questions please call Francine Morgan, The Molar Express Program Manager at 603-259-3700 ext 232.

Child's Medical History

Child's Doctor's Name ______________________________ Doctor's Phone #_______________

Do you have or have ever had any of the following? Please check those that apply:
* This condition may require antibiotic premedication for certain dental procedures.

[ ] Abnormal Bleeding
[ ] ADD/ADHD
[ ] Allergies/Hay Fever
[ ] Anemia
[ ] Artificial Joints*
[ ] Artificial Heart Valves*
[ ] Asthma
[ ] Blood Disorder
[ ] Blood Transfusion
[ ] Breathing Problems
[ ] Cancer
[ ] Chemotherapy
[ ] Cold Sores/Fever Blisters
[ ] Colitis
[ ] Congenital Heart Disorder*
[ ] Diabetes
[ ] Drug or Alcohol Abuse
[ ] Epilepsy or Seizures
[ ] Fainting or Dizziness
[ ] Heart Murmur*
[ ] Heart Surgery
[ ] Hemophilia
[ ] Hepatitis
[ ] Herpes
[ ] High Blood Pressure
[ ] HIV*/AIDS
[ ] Kidney Problems
[ ] Low Blood Pressure
[ ] Mitral Valve Prolapse*
[ ] Organ Transplant
[ ] Psychiatric Disorder
[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Sinus Problems
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Venereal Disease

If you marked "YES" to any items on the above list, please explain: ______________________________

____

Please list any other health conditions your child has ____

____

Is your child allergic to any medications or substances?____
If yes, please check box below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Foods [ ] Other _________________

____

Please list any medications your child is taking ____

Does your child require antibiotics before dental work? ____

Any other information you want us to know about your child?___________________________________

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____

If you have any questions please call Francine Morgan, The Molar Express Program Manager

at 603-259-3700 ext 232.

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Please read and sign this section. I give permission for my child to be considered for The Molar Express program and, if accepted, to receive dental care. Dental care includes cleaning teeth (polishing), topical fluoride treatments, and bite wing x-rays. <u>Sealants and cavity fillings will be provided</u>, only as necessary and as approved by the dentist.

I understand that the dentist will provide a treatment plan for my child before "invasive" care is provided, such as extractions. Invasive treatment requires an additional signed permission.

I acknowledge that I received a copy of The Molar Express Notice of Privacy Practices.

____ ______________________________

Signature of Parent or Guardian Date

Please return this confidential form to your child's school nurse.