

# 2015/2016 School Year

New form needed EACH year!



a North Country Health Consortium program



The Molar Express is a portable 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. No insurance? We can help! Fill out the form and one of our team members will reach out to you with options.

#### Our contact information:

- Go to our website: [www.nchcnh.org](http://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](mailto:molarexpress@nchcnh.org)
- Address: The Molar Express, 262 Cottage Street, Suite 230, Littleton, NH 03561

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

## The Molar Express

### *Patient's Rights and Notice of Privacy Practices*

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**

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](http://www.cms.hhs.gov/hipaa).

KEEP THIS PAGE FOR YOUR RECORDS



# The Molar Express

PATIENT REGISTRATION FORM



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. 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 and Parent Information:** School Attending \_\_\_\_\_

Child's name \_\_\_\_\_ Nickname: \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Social Security #: -- -- Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex (M) or (F)

(home address) (town) (state) (zip code)

Parent or Guardian Name \_\_\_\_\_ Who does child live with? \_\_\_\_\_

Primary Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (home / cell / work) Alternate Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (home / cell / work)

Do you accept texts? Yes / No Email address \_\_\_\_\_

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

## Child's Dental History

\_\_\_ My child **does not have** a regular dentist. \_\_\_ My child was seen by The Molar Express last year.  
 \_\_\_ My child **has** a regular dentist.

Please list any information you want us to know about your child's dental needs: \_\_\_\_\_

Previous 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? Yes / No

Has your child had fluoride treatments? Yes / No Any adverse reaction to fluoride? Yes / No

## Dental Insurance Information

Does your child have NH/VT Medicaid Insurance (formerly Healthy Kids) ? Yes / No

**If Yes: NH/VT Medicaid Number (ID # at the bottom of the card):** \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscriber's Social Security #: -- --

Subscriber's Employer: \_\_\_\_\_

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

OFFICE USE ONLY:

\_\_\_\_\_  
 \_\_\_\_\_

OVER: PLEASE FILL OUT AND SIGN OTHER SIDE



## Child's Medical History

Regular Doctor's Name \_\_\_\_\_ Doctor's Phone # # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Does child have or has child ever had any of the following? Please check those that apply:

\* This condition may require antibiotic premedication for certain dental procedures.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Abnormal Bleeding        | <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Heart Murmur*          | <input type="checkbox"/> Organ Transplant     |
| <input type="checkbox"/> ADD/ADHD                 | <input type="checkbox"/> Chemotherapy               | <input type="checkbox"/> Heart Surgery          | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Allergies/Hay Fever      | <input type="checkbox"/> Cold Sores/Fever Blisters  | <input type="checkbox"/> Hemophilia             | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Colitis                    | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial Joints*       | <input type="checkbox"/> Congenital Heart Disorder* | <input type="checkbox"/> Herpes                 | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Artificial Heart Valves* | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Drug or Alcohol Abuse      | <input type="checkbox"/> HIV*/AIDS              | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Blood Disorder           | <input type="checkbox"/> Epilepsy or Seizures       | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Blood Transfusion        | <input type="checkbox"/> Fainting or Dizziness      | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Breathing Problems       |   | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> 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? Yes / No 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? Yes / No


Please list all siblings:

- |                |            |               |
|----------------|------------|---------------|
| 1. Name: _____ | Age: _____ | School: _____ |
| 2. Name: _____ | Age: _____ | School: _____ |
| 3. Name: _____ | Age: _____ | School: _____ |
| 4. Name: _____ | Age: _____ | School: _____ |


Do you have any other information you want us to know about your child? \_\_\_\_\_

\*\*\*\*\*

**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. Sealants, regular cavity fillings, and temporary fillings will be provided, only as necessary and in collaboration with the dentist. I understand that the dentist will provide a treatment plan for my child before extractions (removing teeth). Extractions will require an additional signed permission form. If you have any questions, please feel free to call us at (603) 259-3700.

 SIGN HERE \_\_\_\_\_  
Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

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

 SIGN HERE \_\_\_\_\_  
Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

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