Do you need dental care for your child?

Give Kids a Smile offers

FREE DENTAL CARE

for your child or children!

WE WILL BE AT YOUR CHILD'S SCHOOL SOON!

Complete and return this form
to your child's school office.

THERE IS NO COST!

See reverse side for details.

GIVE KIDS A SMILE

MOBILE DENTAL PROGRAM

Dear Parent or Guardian:

Bethany's Give Kids a Smile program provides free dental care for children who cannot afford to get dental care on their own. Our dental bus will come to your child's school. All service individuals are licensed dental professionals.

Your child ***may qualify*** for this program ***if*** he or she:

- ⇒ has never been to the dentist
- ⇒ has not been to the dentist in the last six months
- ⇒ receives Medicaid / the medical card
- ⇒ is not covered under a private dental insurance
  - ⇒ Examples include Humana, Delta Dental, MetLife, etc.

The bus visits schools all over the Quad Cities. On the day that the bus comes to your child's school, your child will receive

- ⇒ oral health education
- ⇒ a dental exam
- ⇒ teeth cleaning
- ⇒ fluoride treatment
- ⇒ sealants, if necessary

THERE IS NO CHARGE FOR SERVICES ON THE GIVE KIDS A SMILE DENTAL BUS

(If your child is enrolled in the state Medicaid system, Medicaid will be billed for services provided on the bus and for any follow-up services that are necessary.)

If you want to have your child participate in this program, please complete the enclosed forms and return it to your school.

Sincerely,

Evena Wash

Evena Wash
Supervisor, Give Kids a Smile

Have questions? Call me at (309) 736-6616!

Follow Bethany for Children & Families on Facebook to see when the Give Kids a Smile bus will be at your child's school!

GIVE KIDS A SMILE — PERMISSION FORM

PLEASE PRINT IN INK

Child's First Name	Child's Last Name	Date of Birth	Gender
		/ /	☐ M ☐ F

Home Address	City	State	Zip Code

Parent/Guardian First Name	Last Name	Phone	Email Address

Emergency Contact Name	Relationship to Child	Emergency Contact Phone

Child's School	Child's Teacher	Child's Grade

Child's Medicaid Recipient ID Number or Hawk-i Number

What race do you consider your child?

- ☐ Black
- ☐ White
- ☐ Hispanic / Latino
- ☐ Asian
- ☐ American Indian / Native Alaskan
- ☐ Hawaiian Native
- ☐ Other Pacific Islander
- ☐ Multi-Racial
- ☐ Other _____

What type of <u>DENTAL INSURANCE</u> does your child have?

- ☐ Humana
- ☐ Delta Dental
- ☐ MetLife
- ☐ Medicaid (Medical Card, Title 19)
- ☐ Meridian
- ☐ Illini Care / Envolve
- ☐ Hawk-i
- ☐ Other _____
- ☐ None

Where does your child go for regular dental care?

Name of Dentist/Office

Date of Last Visit

Has your child been seen on the Give Kids a Smile dental bus before?

- ☐ Yes
- ☐ No

For Office Use Only

GIVE KIDS A SMILE — PERMISSION FORM

PLEASE CHECK IF YES

Bethany for Children & Families

give kids a smile! Children's Dental Access Program

- [ ] **My child needs an antibiotic before a dental procedure.**

- [ ] ADHD / ADD
- [ ] Anemia
- [ ] Artificial Heart Valve
- [ ] Artificial Joints
- [ ] Autism
- [ ] Bleeding Disorder
- [ ] Blood Disorder
- [ ] Brain Injury
- [ ] Cancer
- [ ] Cerebral Palsy
- [ ] Chronic Earaches
- [ ] Chronic Headaches
- [ ] Chronic Pain
- [ ] Diabetes
- [ ] Downs Syndrome
- [ ] Epilepsy
- [ ] Fainting / Dizziness
- [ ] Fever Blisters / Cold Sores
- [ ] Hearing Difficulties
- [ ] Heart Ailment / Angina
- [ ] Heart Attack
- [ ] Heart Murmur / Heart Defect
- [ ] Hepatitis / Liver Problems
- [ ] High / Low Blood Pressure
- [ ] High Cholesterol
- [ ] HIV / AIDS
- [ ] Kidney Disease
- [ ] Leukemia
- [ ] Mental / Physical Disabilities
- [ ] Osteoporosis
- [ ] Pace Maker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Rheumatoid Arthritis
- [ ] Seizure Disorder
- [ ] Stomach Disorder
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Caffeine Use
- [ ] **Allergies**
  - [ ] Latex
  - [ ] Nut
  - [ ] Food
  - [ ] Anesthetics
  - [ ] Metals
  - [ ] Other _____
- [ ] **Medication** — List with Dosage

  _____

  _____

  _____

  _____
- [ ] **Surgeries** — List with Date

  _____

  _____
- [ ] **Asthma** — List triggers below.

  _____

  _____
  - [ ] Carries Inhaler

- [ ] Gum Disease / Bleeding Gums
- [ ] Sensitive / Painful Teeth
- [ ] Jaw Pain (TMJ / TMD)
- [ ] Has Speech Impairments
- [ ] Has Difficulty Chewing Food
- [ ] Gags Easily
- [ ] Bites Nails
- [ ] Breathes through Mouth
- [ ] Grinds Teeth
- [ ] Sucks Thumb / Lips / Inner Cheek
- [ ] Brushes Twice a Day
- [ ] Flosses Daily
- [ ] **Soda / Pop** — How Often?

  _____
- [ ] **Sticky Foods** — How Often?

  _____
- [ ] **Sugary Foods** — How Often?

  _____
- [ ] **Tobacco** — What Type & How Often?

  _____

  _____

For Office Use Only

Sealants Placed:

- [ ] 2
- [ ] 3
- [ ] 14
- [ ] 15
- [ ] 18
- [ ] 19
- [ ] 30
- [ ] 31

Health History Reviewed By:

_____

Dentist's Initials: _____

Date: _____

GIVE KIDS A SMILE — WAIVER FORM

PLEASE READ THE WAIVER BELOW AND INITIAL IN INK IF YOU AGREE TO THE BELOW.

_____ **I give permission for my child to be treated on the Give Kids a Smile dental bus from Bethany for Children & Families.**

_____ **I give permission for Bethany for Children & Families to transport my child from his or her school to the dental bus if the bus is parked off-site.**

_____ **I give permission for my child to be treated in a dental office or clinic if follow-up work is needed.**

_____ **I give permission for Bethany for Children & Families to transport my child to a follow-up dental appointment if I am not able to take my child to the appointment or do not have transportation. Transportation will be arranged on a case-by-case basis.**

_____ **If my child needs a specialist — Pedodontist (for general pediatric dentistry), Endodontist (for root canals), Oral Surgeon (for tooth extractions), Periodontist (for gum disease), or Orthodontist (for braces) — I agree to go with my child to this appointment.**

_____ **I give permission for audits to be performed and professional providers to return to my child's school to recheck his or her sealants and reseal if needed.**

_____ _____

Signature of Parent / Guardian / Legal Custodian **Date**

ACKNOWLEDGEMENT OF RECEIPT OF GIVE KIDS A SMILE NOTICE OF PRIVACY PRACTICES

I, as the parent or guardian, have received a copy of the Give Kids a Smile Notice of Privacy Practices.

_____ _____

Signature of Parent / Guardian / Legal Custodian **Date**

Permission and acknowledgment is valid for one year from the date of signature.

For Office Use Only

We attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices, but acknowledgment was not obtained because ...

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other _____

GIVE KIDS A SMILE

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

Dentists participating in the Give Kids a Smile program may be required by applicable federal and state law to main the privacy of your health information. Protection of patient privacy is important to participants in the Give Kids a Smile program. This notice summarizes the privacy practices that will be followed by participants in the Give Kids a Smile program, and your rights concerning your health information. This Notice will apply to health information collected in connection with the Give Kids a Smile program and will remain in effect until replaced.

You may request a copy of the Notice of Privacy Practices at any time. For more information about the privacy practices, or for additional copies of this Notice, please contact Bethany for Children & Families at (309) 797-7700.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment. For example, we may use or disclose your health information to another dentist, physician, or other health care provider providing treatment to you.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. 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.

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 involved in your treatment to the extent necessary to help with your health care.

Persons Involved in Care: 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 institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us at (309) 797-7700 for assistance in reaching the dentist or facility holding your health information.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last six years, but not before April 14, 2003.

Restriction: You may 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 may request that we communicate with you about your health information by alternative means or to alternative locations. We may agree to reasonable requests.

Amendment: You may 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.

QUESTIONS & COMPLAINS

If you want more information about our privacy practices or have questions or concerns, please contact us at (309) 797-7700. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your health information, or to have us communicate with you by alternative means or at alternative locations, you may contact us at (309) 797-7700. You may also 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.