SMILE EXPRESS
Monongalia County Health Department
Mobile Dental Office

The mission of Smile Express is to provide access to excellent dental care where our community lives and learns.

453 Van Voorhis Rd – Morgantown, WV 26505 (304)598-5108 www.monchd.org/dentistry

Dental Health Services Questionnaire (required)

1. **During the past 6 months, did your child have a toothache?**
   ___ No ___ Yes ___Don't know/can't remember

2. **Approximately how long has it been since your child visited a dentist for checkup/exam? (Check one)**
   ___ 6 months or less ___ 6 months to 1 year ___ More than 1 year ago, but not more than 3
   ___More than 3 years ago ___ Never/don't remember

   Dentist Name _____ Date of last visit _____ Follow-up visit date _____

3. **What was the main reason for your child's last dental visit? (Check one)**
   ___Went in on own for check-up, examination or cleaning ___Called in by dentist for check-up
   ___Something was hurting ___Went for treatment of a condition that a dentist discovered at an earlier check-up or examination ___Other ___ Don't know/can't remember

4. **During the past 12 months, was there a time when your child needed dental care but could not get it?**
   ___ No (Go to #6) ___ Yes (Go to #5) ___Don't know/can't remember (Go to #6)

5. **The last time your child could not get the dental care he/she needed, what was the main reason he/she couldn't get care? (Check one)**
   ___Could not afford it ___Health of another family member ___Not a serious enough problem
   ___ No insurance ___ Difficulty in getting an appointment ___Dentist hours not convenient
   ___Dentist did not take Medicaid/insurance ___Transportation issues ___No dentist available
   ___Unsure of where to go ___Don't like going to dentists ___Speak a different language
   ___Wait was too long in clinic/office ___Other reason ___Don't know/can't remember

6. **Do you have any kind of insurance that pays for some or all of your child's *medical* OR *surgical* care?**
   ___ No ___ Yes ___Don't know

7. **Which of the following best describes your child? (Check all that apply)**
   ___White ___Black/African American ___Hispanic/Latino ___Asian
   ___American Indian/Alaska Native ___Native Hawaiian/Pacific Islander

8. **Is your child eligible for the free or reduced-price lunch program?**
   ___ No ___ Yes

9. **What type of water source do you have at your home? (Check one)**
   ____ Well Water ___ Public Water ___ Don't know

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September 4, 2018

Dear Parent or Guardian,

Smile Express, the mobile dental office operated by the **Monongalia County Health Department**, is coming to your child's school. For those students who do not see a dentist regularly, Smile Express is excited to be offering dental services. **For your student to participate in this innovative program please complete all forms in this packet and return them to their Homeroom/Advisory Teacher by September 10, 2018.**

Smile Express will visit your school sometime in the Fall Semester.

During the visit, your child will receive a dental exam, x-rays, cleaning, fluoride treatment and sealants. If minor restorative procedures are recommended those services will be scheduled at a later date. Parents will be notified by letter and phone call with date of restorative appointment with an invitation to accompany child during visit, if so desired. A letter will be sent home with your child indicating the dental services that were provided, and any other services recommended.

We are sure your child will enjoy their visit to Smile Express. This is a fantastic opportunity to provide important dental care to your child without parents having to miss work. This visit will also fulfill the new recommended dental exam for all PreK, Kindergarten, 2nd, 7th & 12th graders. Seeing the mobile dentist also reduces the amount of time spent away from the classroom, permitting your child to stay in good standing with their attendance.

We look forward to seeing your child soon!

SMILE EXPRESS
Monongalia County Health Department
Mobile Dental Office

PLEASE FILL OUT ALL FORMS COMPLETELY TO AVOID DELAYS

SEE BACK OF THIS LETTER TO BEGIN

IMPORTANT NOTICE & CONSENT

I understand and authorize Smile Express and its affiliated dentists and dental hygienists to provide the following services for the named child for whom I am the custodial parent or legal guardian: dental exam, teeth cleaning, fluoride treatment, X-rays and dental sealants. While it is unlikely your child could be harmed by preventive dental care, in rare cases, the products we use may cause allergic reaction. For additional information regarding the benefits and risks of preventive dental care, please call the number provided. I authorize and direct provider to bill and collect payment from any Medicaid, insurance or other payor. If I have private dental insurance, I will be billed for and agree to pay any deductibles and/or co-pays. Treatment by the in-school dentist may affect future benefits that your child may receive under private insurance, Medicaid or CHIP. Unless I have made prearrangements to attend, and am there by the time of service, services will be provided without my presence. We may send you text messages about the school dental program. Message and/or data fees may be charged to your wireless service provider; to discontinue, reply "STOP" to any message received from us. You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the landline and/or mobile telephone numbers provided on this consent form. I have received the Notice of Privacy Practices (NPP) attached to this form and consent to the release of my child's medical record information, including records obtained from other providers, and any HIV/AIDS, communicable disease, sexually transmitted disease, drug and alcohol and anemia information. I authorize release of such information by provider to any responsible payor and/or administrative service provider and their subcontractors for use and disclosure relating to my child's treatment, payment for services and health care operation purposes. This signed consent authorizes my child's initial and future dental visits. I may withdraw this consent at any time in writing.

LEGAL NOTICE

OUR LEGAL DUTY
Privacy of your medical information is important to us. We are required by applicable federal and state law to maintain 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. We will notify you if your unsecured medical information is breached.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such changed are permitted by applicable law. We reserve the right to make changes in our privacy practices and new terms of our notice effective for all health information that we may 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 health care operations. For example:

Treatment: We may use or disclose your health information to a physician, school nurse or other health care provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our business operations, such as reviewing the competence or qualifications of health care professionals and evaluating practitioner and provider performance.

Your Authorization: Uses or disclosures not otherwise described in this notice may be made only with your written authorization. In addition, we must obtain your written authorization to sell your medical information or to use or disclose your information for marketing goods or services to you in which we are paid to make the communication. 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 medical information for any reason except those described in this notice.

To Your Family and Friends and Persons Involved in Your Care: We may disclose your health information to a family member, friend or other person involved in your care to the extent necessary to the extent necessary to help you with your health care or with payment for your health care. We may also disclose your medical information to disaster relief organizations to help locate individuals during a disaster. We may also use or disclose your medical information to notify or assist in the notification of a family member, a personal representative or a person responsible for your care of your location, general condition or death. If you do not want us to disclose your medical information to family members or others in these circumstances, please notify our HIPAA officer at 304-598-5140.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Safety: We may need to disclose medical information to law enforcement officials, such as in response to a search warrant or a grand jury subpoena, or to assist law enforcement officials in identifying or locating an individual, to report deaths that may have resulted from criminal conduct and to report criminal conduct on our premises.

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 possible victim of other crimes. We may disclose your health information to extent necessary to avert a serious threat to your health or safety or health or safety of others.

National Security: We may disclose your medical information to military authorities of armed forces or foreign military personnel under certain circumstances, to authorized federal officials for lawful intelligence, counterintelligence or other national security activities, and to protect the president, and to a correctional institution or law enforcement official having lawful custody of an 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, letters emails or text messages.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure surveys. These activities are necessary for the government to monitor the health care system, the outbreak of disease, government programs, compliance with civil rights laws and to improve patient outcomes.

Lawsuits and Disputes: We may disclose health information about you in response to a court administrative order. We may also disclose health information about you in response to a subpoena, discovery process or other lawful process.

Other Uses and Disclosures: As permitted or required by law, we may use or disclose your medical information for research purposes to organizations that handle and monitor organ donation and transplantation; for workers' compensation or similar programs that provide benefits for work-related injuries or illness; for public health activities such as to prevent or control disease, injury or disability, to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to, or is at risk for contracting or spreading a disease; to medical examiners to identify a deceased person or determine cause of death; or to funeral directors to carry out their duties.

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information and fax your request to the number at the end of this notice.

Disclosure Accounting: You have a right to receive a list of some of the disclosures we or our business associates have made of your health information. 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 restrict our use or disclosure of your health information. We are not required to agree to your request except when disclosure would be to your health plan (or someone on your behalf other than your health plan) had paid in full for your health care, the disclosure relates to payment or health care operations, and the disclosure is not otherwise required by law. If we agree to the restriction, however, we will abide by that agreement, except in an emergency.

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations specified in your written request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and 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 website or by email, you are entitled to receive this notice in written form upon request.

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, you may complain to us by 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 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 Officer: Daniel T. Carrier, DDS

Phone: 304-598-5108

Fax: 304-598-5110

Effective Date: June 1, 2018

See monchd.org/dentistry for a copy of this notice for your records.

MONONGALIA COUNTY HEALTH DEPARTMENT 19 MCHD 29

Smile Express is bringing dental care to your school.

SMILE EXPRESS
Monongalia County Health Department
Mobile Dental Office

If your child visits a dentist regularly, there is no need to complete or return this form. Please continue to go to that dentist.

Please complete with the information that matches your insurance

Student's Legal Name		Birth Date	☐ Male ☐ Female
Address	City	State	ZIP
School	Homeroom Teacher	Grade	
Parent/Guardian Name	Phone ( )		
Alt Phone ( )	Email		

Health Questionnaire

Does your child have any allergies or medical conditions? If yes, please explain.

_____

Does your child have any dental problems? If yes, please explain.

_____

Please list ALL over-the-counter (OTC) and prescribed (RX) medications taken regularly.

_____

Has the student seen a dentist in the past 12 months? Yes or no. If yes, please provide name and city.

_____

If student has Medicaid or CHIP, please fill out this portion.

Student's Medicaid/CHIP ID number:
_____

Student's Social Security Number:
☐☐☐ – ☐☐ – ☐☐☐☐

If student has private insurance, please fill out this portion.

Member ID:	Group #	Insurance Co. Name
Insurance Co. Phone Number ( )	Employer Name	Name of Insured Adult
Birth Date of Insured Adult	SS# of insured adult ☐☐☐ – ☐☐ – ☐☐☐☐	

If student has no dental insurance, would you be willing to pay for services?

☐ Please contact me ☐ I request funding to cover cost of care if available

Read & Sign Below

I request that the MCHD Smile Express team perform preventive dental care on my child, which can include exam, cleaning, fluoride, sealants and X-rays up to two times in a school year, six months apart. Restorative services are also consented to and a team member will contact me to explain those services recommended and allow me to attend that appointment with my child if additional treatment is needed. I understand at any time I may choose for my child to receive care from another dental provider rather than from Smile Express. I have read the important HEALTH QUESTIONNAIRE above and will report any significant changes in my child's health to 304-598-5108. I have read the IMPORTANT NOTICE AND CONSENT on the back of this form and understand and agree to its terms.

_____ Date _____

Questions? Call MCHD Dentistry at 304-598-5108 FAX 304-598-5110 | Visit us at monchd.org/dentistry.html