SCHOOL/ PROGRAM _____ GRADE _____ TEACHER _____

Each Tooth Truck patient receives an exam and all treatment possible for a cavity-free smile, at NO COST to the patient's family.

The Tooth Truck, Inc, d/b/a Ronald McDonald Care Mobile® of the Ozarks

APPLICATION FOR DENTAL SERVICES

Parents/Guardians: Please fill out the information requested as completely as possible for each child that you would like to be seen by the Tooth Truck for dental services at their school. If you need assistance filling out this form or have questions, please contact the school nurse.

PATIENT INFORMATION (please print clearly)

Child's Name: _____ Date of Birth: ____/____/____ [ ] Male [ ] Female

Parent/Guardian Name(s): _____ Relation to Patient: _____

Phone Number: _____ 2nd Phone: _____ email:_____

Emergency Contact Name & Relation: _____ Phone Number:_____

Child's Social Security Number (if known): _____ Child's Medicaid Number (if known): _____

Does your child have insurance through the state (Medicaid/ MoHealthNet/ Managed Care)? [ ] Yes [ ] No

Does your child have private dental insurance through a parent/guardian's employer? [ ] Yes [ ] No

Is your child eligible for the free/reduced school lunch program? [ ] Yes [ ] No

DENTAL INFORMATION

Is the child having any dental-related pain or concerns? [ ] Yes [ ] No

If yes, please explain: _____

_____

Has the child seen a dentist in the last 12 months? [ ] Yes [ ] No

If yes, approximate date of last dental visit: _____ Name of Office: _____

Please continue to next page -->

ATENCION: Si habla espanol, tiene a su disposicion servicios gratuitos de asistencia linguistica. Llame al 417-891-1238

ACHTUNG: Wenn Sie Deutsch Sprechen, Stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfugung. Rufnummer: 417-891-1238

MEDICAL INFORMATION

Does your child have any medical condition(s) that may affect or complicate dental treatment?
This may include **HEART, BREATHING, BLEEDING, SEIZURE, BEHAVIORAL, ALLERGIES, COMMUNICABLE DISEASE, and/or IMMUNE DISORDERS.** [ ] Yes [ ] No

If yes, please explain: _____

_____

Have you ever been told that your child needs to take an antibiotic prior to dental treatment? [ ] Yes [ ] No

Please list any other medical or behavioral items that our staff should know about to best provide dental care to your child:

_____

_____

PARENTAL/GUARDIAN CONSENT FOR DENTAL TREATMENT

I give consent for my child to receive dental treatment deemed necessary by the providers of The Tooth Truck, Inc. These procedures include, but are not limited to; dental examinations, radiographs (x-rays), cleanings, fluoride varnish, protective sealants of healthy teeth, restorations of decayed or broken teeth (white composite fillings and silver crowns), extraction of baby teeth (due to decay, abscess, or permanent tooth eruption), silver spacers, root canal treatment of severely decayed permanent teeth, and the use of local anesthetics (localized numbing of a section of the mouth). I understand that all dental treatment with anesthetic (numbing) carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect for one year from the date signed.

If my child has active state dental insurance (Medicaid, MOHealthNet or a Managed Care program), I consent and authorize The Tooth Truck, Inc to file and collect reimbursement for dental services performed.

Child's Printed Name:_____ Child's School/Program: _____

Procedure(s) that Parent/Guardian does NOT consent to: _____

Are you the legal guardian of the child? [ ] Yes [ ] No
Are you authorized to sign for Medical Treatment for the child? [ ] Yes [ ] No

Signature of Parent/Guardian: _____ Date Signed: _____

PHOTO CONSENT AND RELEASE

I have read the Photo Consent and Release on page 3 of this form and have indicated my choice below.
Photos may be taken of my child [ ] Yes [ ] No

Signature of Parent/Guardian: _____ Date Signed: _____

NOTICE OF PRIVACY PRACTICE

I have read and understand the release of health information on page 3-4 of this form. My signature indicates my consent to release health information as specified.

Signature of Parent/Guardian: _____ Date Signed: _____

PHOTO CONSENT AND RELEASE

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and for and on behalf and in the name of the child(ren), I hereby consent to the unrestricted use by Ronald McDonald House Charities of the Ozarks, Inc. and The Tooth Truck, Inc. of the Child(ren)'s and our (parents) names, address, and statements, and all video or audio recordings (including, but not limited to , photographs, video tapes, films, voice recording or other representations of our family) taken of our family and any reproduction thereof in any form, style or color whatsoever, together with any writing and/or materials in connection therewith (including, without limitation, any correspondence from our family to Ronald McDonald House Charities of the Ozarks, Inc., The Tooth Truck, Inc. or McDonald's Corporation or anyone affiliated with either organization) for purposes of publicizing the Ronald McDonald Care Mobile of the Ozarks.

For and on behalf and in the name of the family, I hereby release Ronald McDonald House Charities of the Ozarks, Inc., The Tooth Truck, Inc. and McDonald's Corporation and their respective affiliates, franchises, officers, directors, trustees, employees, volunteers, agents, and all other parties interest from any and all present or future claims, damages or causes of action for libel, slander, invasion of privacy or any other claim that the family may have arising out of, resulting from, or in connection with, such use.

I hereby represent that I have read and understand this consent and release is given freely without limitation upon, or liability for, any use in connection with publicizing the Tooth Truck (Ronald McDonald Care Mobile of the Ozarks).

Signature line on page 2

The Tooth Truck, Inc. d/b/a Ronald McDonald Care Mobile® of the Ozarks

NOTICE OF PRIVACY PRACTICE

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

We are required by applicable federal and state law to maintain the 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. This Notice takes effect September 1, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice to be changed at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we 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 operations.

Examples are:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

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

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We are obligated to notify you in the event of a breach of unsecured Protected Health Information (PHI).

Your Authorizations: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us written 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 health information for any reason except described in this Notice. You have a right to an electronic copy of your records. You may request a copy at any time. In the event you pay in full for a service out of pocket, you now have the right to request that we do not disclose treatment information for this service to a health plan.

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 to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. If you are present then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 Protected Health Information (PHI) for marketing purposes without your written authorization. We may use your PHI for fundraising purposes; however, you have the right to opt out by informing us in writing.

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.

(A copy of this notice is also available at www.toothtruck.org.)

Signature line on page 2