

## INSURANCE INFORMATION

If you have insurance, **please send a copy of your insurance card**, it will be billed directly.

Your child may continue to receive services from your own dentist. However, services provided by Commonwealth Mobile Oral Health Services, LLC may affect insurance coverage for other dental visits.

### MassHealth

MassHealth RID Number

\_\_/\_\_/\_\_/\_/\_\_/\_\_/\_/\_\_/\_\_/\_/\_\_/\_\_/\_/\_\_/\_\_/\_/

### DENTAL INSURANCE (Other than MassHealth)

Dental Insurance Company Name

Subscriber's Name (*First, Middle Initial, Last*)

Subscriber's Address (*City State Zip*)

\_\_/\_\_/\_\_/\_/\_\_/\_\_/\_/\_\_/\_\_/\_/\_\_/\_\_/\_/\_\_/\_\_/\_/

Subscriber's Date of Birth (*month / day / year*)

\_\_/\_\_/\_\_/\_/\_\_/\_\_/\_/\_\_/\_\_/\_/\_\_/\_\_/\_/\_\_/\_\_/\_/

Subscriber's Social Security Number

Group Policy Number

Individual Policy Number

Name of Employer

(\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

Insurance Company Telephone #

Insurance Company Address (*City State Zip*)

## TREATMENT DETAILS

### **The dental program is available to all students.**

Services are provided **at your child's school** by Massachusetts licensed dentists. In some cases, dental students may accompany the dental professionals to provide educational and preventive services.

**All students** will receive an oral health screening, a fluoride treatment, and oral hygiene instruction by the dental provider.

**Most students** will receive an exam, treatment plan, dental cleaning, dental sealants, restorations and x-rays as needed.

**Some students** may need to be scheduled for further dental treatment or specialty services and will be referred to a dental provider in your community.

**Referrals** are dependent upon the extent of the dental disease as well as the behavior of the patient.

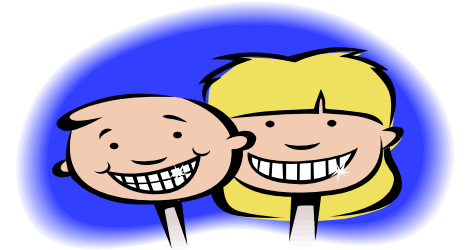
**Informed consent** indicates your awareness of sufficient information to allow you to make an informed personal choice concerning the patient's dental treatment. Most patients do not encounter any difficulties with their treatment. In rare instances, a patient may experience some discomfort or pain. If the patient indicates any resistance to the dental procedure, we will discontinue the treatment

**The Tell-Show-Do** technique is often used to gain the cooperation and confidence of the dental patient. The dental provider explains what they are going to do then shows what they are going to do with instruments on a model. The provider makes every effort to be a partner in care with the patient and family making the dental visit pleasant and informative.

### **CONTACT INFORMATION:**

CMOHS:

(508) 947-0111 or r.unwin@comcast.net



### **Great News!!!**

**Your child can receive the following ongoing DENTAL SERVICES at school**

- ◆ Routine Dental Exams
- ◆ Diagnosis
- ◆ Dental X-Rays
- ◆ Dental Cleanings
- ◆ Fluoride Treatments
- ◆ Preventive Sealants
- ◆ Restorative Dentistry (*fillings*)
- ◆ Oral Hygiene Instruction
- ◆ Recall Visits (*Continuous Care*)

**The dental services listed above are offered to all students in all grades.**

**The signed dental consent will stay in effect while your child attends this school.**

*Commonwealth Mobile Oral Health Services, LLC*  
12 Colleen Drive Lakeville, MA 02347  
Mark J. Doherty, DMD, MPH, CCHP  
Chief Dental Officer

## CONSENT TO PARTICIPATE

Please read, check one box, and sign below

- I understand that this consent may stay in effect while my child attends this school.
- It is the parent/guardian's responsibility to inform the dental provider and/or the school nurse of any changes in their child's medical information
- I understand that a copy of my child's dental report will be given to the school nurse or designated oral health person and that all information about my child will be kept confidential.
- If I have dental insurance, I authorize my insurance carrier to be billed for any services provided.
- I give permission for my child to have fillings with the use of local anesthesia, commonly called "novocaine."
- I have been given a copy of the Commonwealth Mobile Oral Health Services, LLC Notice of Privacy Practices.
- I understand that Commonwealth Mobile Oral Health Services, LLC may use my child's health information for treatment, payment, health care operations, and program evaluation.
- I have read and understand the dental program and I consent to have my child participate in Commonwealth Mobile Oral Health Services, LLC dental program.

### Please Check One Box

**YES**, I give permission for my child to participate in the Oral Health Across the Commonwealth Program.

**NO**, I do not give permission for my Child to participate

\_\_\_\_\_  
Name of Child

**X**

\_\_\_\_\_  
**Signature** of Parent or Legal Representative

\_\_\_\_\_  
**Printed Name** of Parent or Legal Representative

\_\_\_\_\_  
Relationship to the Child

\_\_\_\_\_  
Today's Date

## PATIENT INFORMATION

Please be sure to complete all sections.

\_\_\_\_\_  
Child's First Name                      Last Name

\_\_\_\_\_  
School Name                      Grade                      Room Number

\_\_\_\_\_  
Address: Number                      Street                      Apt.

\_\_\_\_\_  
City                                      State                      Zip

\_\_\_\_\_  
Child's Date of Birth (*month / day / year*)

Gender:    Female \_\_\_\_\_ Male \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian Name

\_\_\_\_\_  
Best phone number to reach parent (home, cell, or work)

\_\_\_\_\_  
Another phone number for parent (home, cell, or work)

\_\_\_\_\_  
Parent email address

Has your child been to the dentist in the past year? yes \_\_\_ no \_\_\_ If **yes**, please write the date and reason for visit. \_\_\_\_\_

What language does parent speak? \_\_\_\_\_

What is your child's race?

- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> Mixed   |
| <input type="checkbox"/> American Indian/Alaska Native    | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Black/African American           | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Hispanic                         | <input type="checkbox"/> White   |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander |                                  |

## MEDICAL INFORMATION

Please be sure to complete all sections.

Does your child see a doctor for regular checkups?  
yes \_\_\_ no \_\_\_

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Physician's Phone

Does your child have **allergies**? yes \_\_\_ no \_\_\_  
If **yes**, please check all that apply: Antibiotics,  
Colophonium, Foods, Latex, Penicillin,  
Resins, Medications (list) \_\_\_\_\_  
Other: \_\_\_\_\_

Does your child need **antibiotics** before dental treatment? yes \_\_\_ no \_\_\_ If **yes**, please explain: \_\_\_\_\_

Does your child take **medications** on a routine basis? yes \_\_\_ no \_\_\_ If **yes**, please list: \_\_\_\_\_

Does your child have a **developmental disability**? yes \_\_\_ no \_\_\_ If **yes**, please explain: \_\_\_\_\_

Has your child ever had any of the following?  
**Please check YES or NO for each condition:**

- | YES                      | NO  | YES                      | NO  |
|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> AIDS/ARC/HIV     | <input type="checkbox"/> | <input type="checkbox"/> Asthma                   |
| <input type="checkbox"/> | <input type="checkbox"/> Birth Defects    | <input type="checkbox"/> | <input type="checkbox"/> Blood Disorders          |
| <input type="checkbox"/> | <input type="checkbox"/> Cytomegalovirus  | <input type="checkbox"/> | <input type="checkbox"/> Congenital Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy/Seizures        |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting Spells  | <input type="checkbox"/> | <input type="checkbox"/> Heart Disease            |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> | <input type="checkbox"/> Heart Murmur             |
| <input type="checkbox"/> | <input type="checkbox"/> Herpes           | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure      |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorder          |
| <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> | <input type="checkbox"/> Pins/Broken Bones        |
| <input type="checkbox"/> | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> Stomach/GI Disorder      |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____     |                          |   |