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.

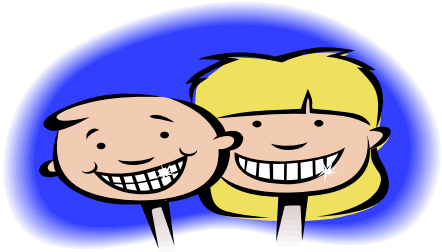
Referrals are dependent upon the extent of the dental disease as well as the behavior of the patient.

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 <u>one</u> 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 <u>Notice of Privacy Practices</u>.
- 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.

<u>Please Check One Box</u>

☐ **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?

☐ Asian
☐ American Indian/Alaska Native
☐ Black/African American
☐ Hispanic
☐ Native Hawaiian/Pacific Islander
☐ Mixed
☐ Other
☐ Unknown
☐ White

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	
☐	☐	AIDS/ARC/HIV	☐	☐	Asthma
☐	☐	Birth Defects	☐	☐	Blood Disorders
☐	☐	Cytomegalovirus	☐	☐	Congenital Heart Disease
☐	☐	Diabetes	☐	☐	Epilepsy/Seizures
☐	☐	Fainting Spells	☐	☐	Heart Disease
☐	☐	Hepatitis	☐	☐	Heart Murmur
☐	☐	Herpes	☐	☐	High Blood Pressure
☐	☐	Rheumatic Fever	☐	☐	Kidney Disorder
☐	☐	Tuberculosis	☐	☐	Pins/Broken Bones
☐	☐	Venereal Disease	☐	☐	Stomach/GI Disorder
☐	☐	Other: _____			