# ST. MARY'S MOBILE DENTAL CARE FOR KIDS

**(Please read all of this page)**

Dear Parent or Guardian:

Once again, ST. MARY'S MOBILE DENTAL CARE FOR KIDS will be coming to your child's school throughout the year.

What does this mean to you?

For the past 10 years the ST. MARY'S MOBILE DENTAL CARE FOR KIDS has been treating children in the Evansville area. ST. MARY'S MOBILE DENTAL CARE FOR KIDS offers full dental services such as dental checkups, cleanings, fluoride treatments, x-rays, sealants, extractions, treatments for toothaches and education for good oral hygiene. All children are welcomed. However, if your child currently has a dentist, we encourage you to stay with your dentist.

➢If you DO NOT WANT your child to be seen on the dental clinic STOP! Disregard SIGN-UP PACKET.

MEDICAID/HOOSIER HEALTHWISE, PRIVATE/COMMERCIAL DENTAL INSURANCE and PRIVATE PAYMENT are accepted.
We have Health Access Advocates on staff to assist you with application for Hoosier Healthwise. PLEASE CALL 485-5864 FOR ASSISTANCE. If you do not qualify for Hoosier Healthwise or you have no other source of payment, financial assistance may be available upon request.

Our goal is to provide a fun, positive experience and the best dental care available for your child. In order for your child to be a patient and receive treatment the following forms MUST be completed and returned to your child's school nurse or daycare personnel as soon as possible. Please fill in both forms completely with particular care given to signature and date in the Authorization box on the back side of the HEALTH HISTORY form. ALSO, on the following page please fill out the top portion of the hospital Consent with your child's **name** and date in paragraph 11. you MUST put your initials and you MUST SIGN at the bottom of the page. If forms are not complete and signed, treatment could be delayed.

PLEASE NOTE:

➢The dentists who work for St. Mary's Mobile Dental Care for Kids are employees of St. Mary's Hospital and WILL NOT send a separate bill for treatment.

You may call the following numbers for additional information:
(812) 485-5843 (office) or (812) 431-5070 (dental clinic)

**St. Mary's Mobile Dental Care for Kids**
**HEALTH HISTORY PACKET**
**(812)485-5843 (812)431-5070**

| For Office use only |
|---|
| Read Date:_____ |
| RTC Due:_____ |
| Chart #:_____ |

DATE _____ SCHOOL _____ GRADE _____

## Patient Information

**(If your child has been seen on the dental clinic before and you would like for them to be seen again you MUST complete the attached forms as we need new paperwork every year.)**

Child's Name _____ Home Phone _____ Cell Phone _____
**First Name** **Last Name**

Sex: ☐ Male ☐ Female Age _____ Birth Date _____ Social Security # _____

Home Address _____ _
Street City State Zip Code

Do you have legal custody of this child? ☐Yes ☐No **If NO, STOP!**

**Forms must be completed by parent or legal guardian or foster parent**

**Father's/Guardian's Name**_____ **Mother's/Guardian's Name**_____

Address (if different from patient's) _____ Address (if different from patient's) _____

_____ _____

Home Phone _____ Cell Phone _____ Home Phone _____ Cell Phone _____

Employer _____Work Phone_____ Employer _____Work Phone _____

Social Security #_____ Birth date _____ Social Security # _____ Birth date _____

➢**List all siblings with their first and last names**: _____

_____

**Does your child have Hoosier Healthwise? ☐Yes ☐ No If yes, Hoosier Healthwise Number:** _____

**If you currently have Private or Commercial Dental Insurance for your child please complete the REQUIRED DENTAL INSURANCE INFORMATION**

Policy Holder _____ Plan Name _____ Employer _____

SS # or Policy Number _____ Date of Birth _____Group Number _____

Billing Address #_____ City _____ State _____ Zip _____

Dental Insurance Phone Number _____

## Dental History

**(If your child is to be seen on our dental clinic, please be sure your child is NOT currently seeing another dentist.)**

Has your child seen a Dentist in the last 12 months? ☐ Yes ☐ No

Name of Dentist _____ Date of last dental visit _____ For what service? _____

Has child complained about dental problems? ☐Yes ☐ No If Yes, please explain: _____

Any mouth habits – thumb sucking, finger sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? ☐ Yes ☐ No

If Yes, please explain: _____

➢**Has your child been informed by a physician that he/she needs to be PRE-MEDICATED before dental treatment due to a heart murmur or other medical condition? ☐ Yes ☐ No If Yes, please explain:** _____

**Please Complete Both Sides**

## Medical Summary

Child's Physician _____ City/State _____ Phone _____

Is child under the care of a physician now? ☐ Yes ☐ No

If yes, please explain_____

Is child receiving any medication or drugs? ☐ Yes ☐ No

If yes, List Current Medications (Including over the counter and /or herbal)

_____

Ever been hospitalized? ☐ Yes ☐ No

If yes, why? _____

Ever had surgery? ☐ Yes ☐ No

If yes, why? _____

Does Child experience chronic pain? ☐ Yes ☐ No

If yes, please explain: _____

Is your child allergic to Latex, any foods, medications, environmental allergens, or other? ☐ Yes ☐ No

List All Known Allergies _____

**HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CIRCLE**

| | | | | |
|---|---|---|---|---|
| **AIDS/HIV** | **Cerebral Palsy** | **Diabetes** | **Hemophilia** | **Pregnancy** |
| **ADD or ADHD** | **Chronic Illness** | **Drug/Alcohol Abuse** | **Hepatitis** | **Psychiatric/Psychological Care** |
| **Anemia** | **Cognitive Disorders** | **Emotional Disorders** | **Joint Replacement** | **Rheumatic Fever** |
| **Asthma** | **Communication Disorders** | **Fainting or Dizzy Spells** | **Kidney Disease** | **Seizures** |
| **Behavioral Disorders** | **Convulsions** | **Hearing Problems** | **Sickle Cell Anemia** | **Tuberculosis** |
| **Blood Transfusion** | **Depression** | **Heart Murmur** | **Mental Disorders** | **Vision Problems** |
| **Cancer** | **Developmental Disability** | **Heart Problems** | **Mobility Problems** | |

**Other**_____

**Special Needs Explain:** _____

Is there anything special about your child spiritually, socially, culturally and/or environmentally that we should be aware of?

If yes, please explain _____

Does your child have a language barrier? ☐Yes ☐ No If yes, will they need an interpreter? ☐ Yes ☐ No

## Nutrition Screening

1. Is your child on a special diet? ☐Yes ☐No
2. If yes, please describe:_____
3. Does your child have any difficulty with eating, chewing or swallowing? ☐ Yes ☐No
4. Has your child had any unintended weight loss of 10 or more pounds in the last three months? ☐Yes ☐No

## Emergency Information

In the event of an emergency, whom should we contact (other than yourself)?

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

## Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge, I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for my child, and I agree to notify the dentist if any change in my child's health status should occur. I understand that St. Mary's must at times collaborate with other outside facilities to coordinate treatment and hereby authorize release of information to these facilities when necessary for treatment of my child. I authorize the dental staff to perform any necessary dental services my child may need. I also authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

**SIGNATURE OF PARENT OR GUARDIAN _____Date_____**

**Reviewed by (Staff Signature)_____Date_____**

**If verbal consent, Staff Signature_____ Staff Witness_____Date_____**

MUST have Signature at bottom of Consent Form (Next page)→→→→→→→→→→→→→→→→→→→→→→

**ST. MARY'S MEDICAL CENTER**
3700 WASHINGTON AVENUE
EVANSVILLE, INDIANA 47750
(812) 485-4000

# Consent For Admission To Hospital, Medical Treatment, Release Of Information And Responsibility

Name:_____ Date:_____ Time:_____

1. I/We the undersigned, voluntarily give my (or the patient's) consent for inpatient or outpatient diagnostic procedure(s) and/or medical or surgical care and treatment as ordered and under the supervision of an admitting or attending licensed practitioner or whomever he/she designates, who is (are) credentialed to admit and treat patients at St. Mary's Medical Center (SMMC).

2. I/We are aware that the practice of medicine and surgery is not an exact science and I/We acknowledge that no guarantees or assurances have been made to me/us with regard to the results that may be obtained from treatments or examinations in the hospital.

3. I/We acknowledge that SMMC of Evansville, Inc., does not assume responsibility for loss or damage to personal property kept in the patient's room. I/We further acknowledge that while the safe is available for the keeping of money and valuables of the patient, SMMC of Evansville, Inc., assumes no responsibility for any possessions deposited therein.

4. I/We consent to allow students from formal education programs for health care professions to participate in my/the patient's care, under the supervision of appropriately licensed and/or credentialed members of such disciplines.

5. If applicable, I/We authorize SMMC's pathologists to use their discretion in the disposal of any specimen or tissue obtained from myself (the patient) in the course of diagnosis or treatment.

6. I/We understand that some insurance companies require prior authorization for inpatient admissions, outpatient services or specific procedures, and that maximum reimbursement may not be received if authorization is required and I/We do not have it. I/We assume the responsibility of obtaining such authorization if necessary and understand that SMMC cannot obtain such authorization for me/us.

7. I/We assign all insurance benefits due to or received by me/us to SMMC of Evansville, Inc., and/or the doctors involved with my/the patient's care including those performing x-ray services, anesthesia services, pathology services, emergency services, or other similar services as total or partial payment for services provided. I/We understand that this assignment may not constitute full payment of my/the patient's bill, and does not relieve me/us from liability for the unpaid balance. If insurance benefits to which I/the patient are entitled are paid directly to me/us, such benefits will upon receipt be immediately delivered to SMMC (or the appropriate physician) by me/us until the full amount of all charges incurred are paid in full.

   I/We agree to pay directly to SMMC and/or said doctors the charges incurred for services received, at their established rates. I/We will pay all attorney fees and court costs incurred by SMMC or said doctors in collecting any unpaid balances for services I/the patient received.

8. I/We acknowledge that I/we received written information regarding my/the Patient Rights protected by St. Mary's Medical Center and written information on the Indiana State Law pertaining to Advance Directives, which gives me (the patient) the right to choose in advance, such things as living will, the appointment of a health care representative or power of attorney for health care purposes. Additionally, in the event that I (the patient) have already executed a valid Advance Directive, I will provide a copy of this document at this admission.

9. I understand that I may request to review my Medical Record during the course of this Hospital stay.

10. If applicable, I/we authorize the delivery, care and treatment of both mother and newborn infant as explained by the designated physician(s). I/We consent to the performance of any other procedures considered necessary by the physician on the basis of findings during the course of care and treatment of mother and/or infant. I/We specifically understand that I/we are consenting not only to my/the mother's care, but the care of the newborn as well.

11. **ACCIDENTAL EXPOSURE OF HEALTHCARE STAFF**: In the course of hospital care and treatment, physicians, nurses and other healthcare staff may accidentally be exposed to a patient's blood or body fluids (through needle sticks, blood splattering, etc.). Communicable diseases, including Hepatitis B, C, HIV Virus, and others are known to be transmitted through exposures of this type. I authorize testing to include HIV and Hepatitis B and C if a healthcare worker should be accidentally exposed to my blood or bodily fluid. I understand that if tests are required, they will be performed at no cost to me. A licensed Independent Practitioner will be in contact with me if the results indicate this.

**12. Independent Status of Physicians: I understand that some or all, of the physicians who will provide services to me while at St. Mary's Medical Center are independent contractors and are not agents or employees of St. Mary's. St. Mary's consents to independently contracted physicians or groups to perform specific services, including but not limited to, Radiology, Emergency Medicine, and Anesthesia, for patients. Those physicians are not employed by St. Mary's. Rather they are independent medical practitioners who have been granted the privilege to use the facilities at St. Mary's for my care and treatment. I can expect to receive a separate bill from those physicians or physician groups.**

**I have read this paragraph Initials** ☐

**St. Mary's Medical Center's Notice of Privacy Practices provides information about how protected health information about me (the patient) may be used and disclosed. By signing this form, I acknowledge that I have been offered and/or received St. Mary's Medical Center's Notice of Privacy Practices.**

**DO NOT SIGN THIS FORM UNTIL YOU HAVE READ THE ENTIRE FORM AND UNDERSTAND ITS CONTENTS. PLEASE ASK QUESTIONS IF YOU ARE NOT SURE ABOUT ANYTHING ON THIS FORM.**

If signed by person other than the Patient, please check the appropriate box indicating why the Patient can not give own consent:
☐ Patient's Age (Minor) ☐ Medical Condition

| Witness | Patient/Closest Relative/Legal Guardian | Date/Time |
|---|---|---|



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