

COMPLETE AND RETURN FORM TO YOUR SCHOOL FOR YOUR CHILD TO RECEIVE MEDICAL AND DENTAL SERVICES ON THE MOBILE UNIT



Rural Health Services (RHS) located at 1000 Clyburn Pl, Aiken, SC has partnered with your child's school to provide dental and medical services on the **Clyburn Community Health Express Mobile Unit** during school hours. One benefit of the program is that your child will only be out of the classroom 30-45 minutes instead of 1/2 or full day when they visit the dentist or doctor outside of school.

Primary Care Services Include: Well child exams, medical assessments and treatment. Well child exams include head to toe examination, screenings (hearing, urine, blood), as well as a genital exam to monitor growth and development. Another adult is present for the genital exam.

Dental Services Provided Include: Exam, x-rays, cleanings, sealants and limited additional treatment that include fillings and pediatric stainless steel crowns. Treatment plans will be sent home for parent consent prior to operative work (fillings, crowns, etc).

Already Has a Doctor or Dentist? If your child already has a dentist or doctor, you should keep going to that dentist or doctor.

Want Your Child to Participate? Complete this form and return it to your child's school within the next two (2) days. **Complete all insurance and health history information.** The information can only be filled out by a parent or legal guardian and must be filled out in ink.

Check the one that applies. I want my child to be seen by Medical Staff Only Dental Staff Only Both Medical and Dental.

Returning this form to your child's school indicates that you would like to proceed with care on the **Clyburn Community Health Express**.

Child Information

School: _____ Grade: _____ Teacher: _____
 Child's First and Last Name: _____
 Gender: F M Transgender Parent/Guardian Email: _____
 Sexual Orientation: Straight/heterosexual Bisexual Lesbian, gay, or homosexual Something else
 Don't know Choose not to disclose
 Address (City, State, and Zip and Apt#): _____
 Date of Birth: _____ Age: _____ Child's Social Security#: _____
 Primary Phone: (____) _____ Day Phone: (____) _____ Cell: (____) _____
 Name of Your Child's Primary Doctor: _____ Dentist: _____ N/A: _____

Race (circle): American Indian Alaskan Native Asian Black/African American Native Hawaiian Caucasian Other Pacific Islander
 Multiple Races Other Unreported/Refuse to Report

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Language (circle): English French German Italian Japanese Spanish Portuguese Sign Language Other Decline to Answer

Housing (circle): Single Family Home Homeless Multiple Family Home (Doubling Up) Transitional Housing (Shelter) Other Decline to Answer

INSURANCE INFORMATION: As the **Responsible Party**, I understand that my dental or medical insurance carrier or payer of my benefits will be billed for services rendered. Medicaid or private insurance is accepted as payment in full for service(s). If your child's insurance changes during the year, make sure that we get an updated copy of your insurance card and/or updated insurance information.

CHILD HAS MEDICAID:

Medicaid Provider: _____
 Medicaid #: _____

CHILD HAS PRIVATE INSURANCE:


Insurance Company Name: _____ Phone # of Company: _____
 Policy Holder's Name: _____ Employer: _____
 Policy Holder's ID or SS# _____ Group# _____ Policy Holder's DOB: _____
 Primary Phone: (____) _____ Day Phone: (____) _____ Cell: (____) _____

CHILD HAS SEPARATE DENTAL INSURANCE:

Insurance Company Name: _____ Phone # of Company: _____
 Policy Holder's Name: _____ Employer: _____
 Policy Holder's ID or SS# _____ Group# _____ Policy Holder's DOB: _____
 Primary Phone: (____) _____ Day Phone: (____) _____ Cell: (____) _____

CHILD IS UNINSURED (NO INSURANCE): Call (803) 380-7000 For Information and Help!

FAMILY INFORMATION: Parent /Guardian: _____
 Address (If different from child's) _____
 Home Phone: (____) _____ Day: (____) _____ Cell: (____) _____
 Choice of Pharmacy: _____ Address/Phone # of Pharmacy: _____
 Family Yearly Income Level: \$ _____ Decline to Answer _____ Email: _____

 Date of the last time your child saw a dentist or doctor? Dentist: _____ Doctor: _____

Would you like any other adult to be able to give permission to treat your child? This would also allow the dental and medical team to talk about your child's health, treatment, and recommendations with this adult. If yes, please provide:

First and Last Name: _____
 Phone number: _____ Relationship to child: _____

Medical History: Write Yes (Y) or No (N) on the line provided beside the question.

Has the student had surgery in the past? If yes, EXPLAIN why: _____
 Are any of the child's teeth causing pain? _____
 Does the child smoke, use tobacco and/or recreational drugs? _____
 Is the student pregnant or possibly pregnant? _____
 Have there been any changes in the student's health in the past year? EXPLAIN: _____
 Has the Student ever been hospitalized overnight? If so list dates, and the reason? _____
 Has the student had any serious or sport related injuries? _____
 Does the student have any allergies (food, medication, anesthetics, latex, etc.)? If so, List: _____
 Has your child been in contact with the AIDS virus or have they been tested positive for HIV? _____
 Does your child take any daily medications, including over the counter or inhalers? _____. If Yes, explain _____.

- | | |
|--|--|
| <input type="checkbox"/> High or low Blood Pressure | <input type="checkbox"/> Stroke or mini-stroke |
| <input type="checkbox"/> Ulcer or Acid Reflux | <input type="checkbox"/> Congenital Heart Disease (Heart defects noted from birth) |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Anemia (including sickle cell anemia) Type: _____ |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Artificial or prosthetic heart valve, stent, or graph |
| <input type="checkbox"/> Recent Blood Transfusion | <input type="checkbox"/> Epilepsy and/or Seizure |
| <input type="checkbox"/> Bacterial Endocarditis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cortisone Steroid Treatment | <input type="checkbox"/> Sinus Problems (hay fever) |
| <input type="checkbox"/> Heart conditions including murmur | <input type="checkbox"/> Cancer/Radiation/Chemo |
| <input type="checkbox"/> Nervous Disorder or Behavioral Problems | <input type="checkbox"/> Learning Disability or Special Needs |
| <input type="checkbox"/> Artificial Joints | |
- Sexually Transmitted infection (Disease). EXPLAIN: _____
 Asthma, Breathing Problems or lung disorder? EXPLAIN: _____
 Kidney Trouble, EXPLAIN: _____
 Tuberculosis, MRSA, or any other infectious disease. EXPLAIN: _____
 Asthma- List Triggers and date of last attack _____
 Liver disease, Hepatitis, jaundice, bleeding disorder or history of Leukemia. EXPLAIN: _____
 Does your child have any other medical problems not listed? If yes, please list and explain: _____

Authorization

- I authorize the dental staff to perform diagnostic procedures and treatment as may be necessary for proper dental care, including (but not limited to) exams, x-rays, prophylaxis, and sealants. I also authorize the dentist to perform further treatment as indicated on the treatment plan sent home with my child.
- I authorize the medical staff to perform a well-child checkup, medical assessment and treatment.
- I authorize the RHS medical staff to immunize my child if needed.**
- I authorize the RHS mobile unit medical staff to administer a flu shot if needed.**
- I authorize the release of any information concerning my child's health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize the release of any information regarding my child's healthcare, advice, and treatment to another dentist, doctor, or school nurse.
- I hereby authorize payment of insurance benefits directly to Rural Health Services, otherwise payable to me.
- I attest to the accuracy of the information contained within this packet. I understand that it is my responsibility to inform the RHS staff of any changes in my child's medical status at the very next appointment before any treatment is rendered.
- I understand that this authorization to receive medical and dental services on the mobile unit is valid each year services are offered until I revoke it in writing.**

Acknowledgment of Receipt of Notice of Privacy Practices and Authorization of PHI Disclosure

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights can be found at www.HHS.gov. By returning this form to my child's school, I acknowledge my understanding of my rights concerning HIPAA. I also am aware that treatment plans that may contain health information may be sent home with my child for my review. I understand that I may revoke this authorization at any time by contacting RHS at the contact information listed below.

Parent or Guardian Signature: _____

Date: _____

Call **(803) 380-7000** if you have questions about this program or care received on the mobile unit.