Revised 05-18

SCHOOL _____ 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
949 E. Primrose St., Springfield, MO 65807

## PATIENT INFORMATION FORM

Parents/Guardians: The information requested below is of great value in aiding us to a better understanding of your child. In order for your child to receive dental care provided by The Tooth Truck, Inc. you will need to complete this form for your child. Please make your answers as complete, legible and accurate as possible. This will help us provide the best possible health services for your child. This information form becomes part of our permanent record and will be held in strict confidence. Please circle YES or NO where indicated. If you are unable to complete this form by yourself or have questions, please contact the school nurse. Thank You.

1. Name of Child: _____ Preferred Name: _____
2. Date of Birth: ____/____/_____ Age of Child ____ Sex : Male _____ Female _____
3. Home Address: Street_____
   City_____ State_____ Zip_____
4. Phone Numbers: Home (_____)_____
   Work (_____)_____
   Mobile (_____) _____
   Email _____
   Privacy Restrictions: No Phone Calls _____
   No Correspondence_____
   Disclosure Restrictions_____

PREFERRED METHOD OF COMMUNICATION
__ Text
__ Phone Call
__ Email

MANAGED CARE / MEDICAID PROVIDER
__ Home State Health-Envolve
__ MO Care-DentaQuest
__ United Health Care-Scion

5. Does your child have Medicaid/MC+?.....YES.....NO
6. Does your child have dental insurance? (excluding Medicaid).....YES.....NO
   Social Security Number _____ Medicaid/MC+ Number_____
7. Is your child eligible for free/reduced school lunches?.....YES.....NO
8. Please check the reason(s) for seeking dental care:
   _____Routine checkup _____Toothache _____Accident to teeth _____Swelling of face
   _____Other (specify) _____
9. Person to Notify in case of Emergency OR Parent/Legal Guardian's name and address if different from child's.

Name: _____ Relation: _____
Address: _____ Phone number: _____

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 417-891-1238.

## DENTAL HISTORY

1. Is this your child's first dental visit?.....YES.....NO If not, who is your child's dentist? _____

2. Have there been any injuries to your child's teeth or jaw?.....YES.....NO
If yes, describe_____
_____

3. Is your child complaining of teeth, gums, or mouth pain?.....YES.....NO Specify: _____
_____

4. Do you have any special concerns about your child's teeth, gums, or mouth?.....YES.....NO Specify:_____
_____
_____
_____

## ETHNICITY

Please CIRCLE the most accurate description of your child's ethnicity. This information is pooled with that of Ronald McDonald Care Mobiles throughout the country to provide an accurate picture of not only ethnicity, but other attributes about people that utilize our programs.

| | | |
|---|---|---|
| Aboriginal | East Indian | Native American |
| Arabic/Middle Eastern | First Nation | Other |
| Asian | Hispanic | Pacific Islander |
| Black/African Descent | Latino | 2 or more Ethnicities |
| Caucasian | Maori | Decline to answer |

## MEDICAL HISTORY

1. Child's Physician _____ City _____
Date of Last Visit to Physician _____
2. Is your child presently under the care of a physician for any medical problem? YES NO
If yes, for what? _____
3. Is your child taking any medications? YES NO
Specify?_____
4. Has your child ever been hospitalized or had surgery? YES NO
For what?_____
5. Does your child have any allergies? YES NO Specify?_____
6. Approximate Weight: _____
7. Does your child have a history of:

| | | | | | |
|---|---|---|---|---|---|
| Penicillin allergy | YES | NO | HIV+ | YES | NO |
| Latex allergy | YES | NO | AIDS | YES | NO |
| Excessive or prolonged bleeding | YES | NO | Cerebral palsy | YES | NO |
| High blood pressure | YES | NO | Behavioral problems | YES | NO |

**MEDICAL HISTORY (continued)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Sickle cell disease | YES | NO | ADHD | YES | NO | Heart condition | YES NO |
| Sickle cell trait | YES | NO | Aspergers | YES | NO | If "YES", complete the following | |
| Kidney disease | YES | NO | Autism | YES | NO | Artificial heart valve | YES NO |
| Rheumatic fever | YES | NO | Asthma | YES | NO | Infective endocarditis | YES NO |
| Ear infections | YES | NO | Liver disease | YES | NO | Cardiac transplant | YES NO |
| Fainting | YES | NO | High fevers | YES | NO | Congenital heart condition | YES NO |
| Diabetes | YES | NO | Tonsillitis | YES | NO | | |
| Tuberculosis (TB) | YES | NO | Dizziness | YES | NO | | |
| Birth defects | YES | NO | Anemia | YES | NO | | |
| Cancer or tumors | YES | NO | Hepatitis | YES | NO | | |
| Speech problems | YES | NO | Nutritional problem | YES | NO | | |
| Hearing problems | YES | NO | Convulsions or seizures | YES | NO | | |
| Blood transfusion/products | YES | NO | Vision problems | YES | NO | | |
| Radiation treatment | YES | NO | | | | | |

8. Please list any special problems or anything you feel we should know about.

_____

_____

_____

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## If filling out this application for multiple children, you may complete the remainder of this application ONCE, listing all children's names where applicable.

### DENTAL TREATMENT CONSENT AND AGREEMENT

I hereby authorize and request the performance of dental services for the following child(ren),_____, at no charge to myself, consisting of dental x-rays, diagnosis, topical fluoride application and other preventive measures as well as restorations, space maintainers, extractions, crowns and other dental procedures as indicated by treatment prescription by The Tooth Truck, Inc..

I understand that The Tooth Truck, Inc. will use restorative, oral surgery, and patient management techniques that are reasonable, necessary, and advisable.

I, _____, as a legally responsible guardian of the following child(ren) _____ give my consent for the use of local anesthetics, and nitrous oxide as deemed appropriate by The Tooth Truck, Inc. in performing dental treatment as deemed necessary with the exception of the following dental procedure(s) _____(Write "None" if you give permission for all dental procedures prescribed).

I hereby and on behalf of the following child(ren) _____ who is/are under the age of eighteen (18) years, consent that said child(ren) may participate in the dental services provided by The Tooth Truck Inc. (d/b/a/ Ronald McDonald Care Mobile of the Ozarks), and do hereby consent that their dentist and other agents and employees may furnish to School District employees (i.e. School Nurse) and/or authorized organizations all information concerning said child's case history, dental examination, written reports, to include photographs pertaining thereto, with respect to said dental examination and findings thereof. An authorized organization is one that has been approved by The Tooth Truck, Inc. Board of Directors.

**(DENTAL CONSENT AND AGREEMENT continues on next page)**

**DENTAL CONSENT AND AGREEMENT (continued)**

The undersigned further hereby consents and authorizes the agents and employees of The Tooth Truck, Inc. to file and collect Missouri Medicaid/MC+ reimbursement for dental services performed.

Further, I certify that I understand and agree to the conditions set forth above.

Are you currently the legal guardian for this child(ren)? YES NO

Can you sign for Medical Treatment? YES NO

Name of Parent/Guardian _____

Relationship to child(ren) _____

Signature _____ Date _____

Due to the high demand for dental appointments, The Tooth Truck, Inc. will only tolerate ONE missed appointment. If a family needs to reschedule an appointment they must contact their school nurse or the Tooth Truck (417-891-1238) before their scheduled appointment. Families missing TWO scheduled appointments will be dismissed from the clinic and will not be rescheduled.

Name of School Nurse _____

School _____

## PHOTO CONSENT AND RELEASE

I hereby represent that I am the parent/legal guardian of:

_____ _____ _____
Name Birthdate

_____ _____ _____
Name Birthdate

Herein called "the child(ren)."

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 familly to Ronald McDonald House Charities of the Ozarks, Inc., The Tooth Truck, Inc. or McDonald's Corporation or anyone affilliated 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 affiliatees, 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 famiily 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).

_____
Date

_____
Signature

_____
Name (Please Print) of Parent/Legal Guardian

If you prefer that we do NOT take photographs of your child, please cross out the above paragraph and sign below. (These do not include x-rays and internal photos referenced in dental treatment consent.)

Please do not take photos of my child.

(SIGNATURE) _____

# PRIVACY PRACTICES

Patient Rights and Information

Each Patient shall have the right to:

1. Be treated with Respect and Dignity
2. The Tooth Truck complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, sexual orientation, disability, or sex.
3. Safe and efficient treatment
4. Voice their personal feelings via verbal or written means
5. Information concerning their diagnosis, and planned treatment for their Dental needs
6. Obtain information as to any relationships this facility has with other professional individuals or medical facilities, in so far as their care is concerned
7. Expect confidentiality in communications and records pertaining to their dental treatments
8. The information necessary to give informed consent to treatment

Patient Responsibilities

Each Patient shall be responsible for the following:

1. Provide accurate and complete information for use in notification of Dental needs and appointments
2. Keep appointments and for notifying Tooth Truck staff if unable to do so
3. To make known their understanding and agreement of treatment needs
4. Being respectful and considerate of all staff and other patients being treated by the Tooth Truck
5. For their own actions should they refuse treatment or for not following instructions given to them by the Dental staff
6. To provide responsible transportation and assistance if needed
7. To follow all Tooth Truck policies and procedures

Acknowledgement of Receipt of Notice of Privacy Practices

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

I, _____, (Print parent/legal guardian's name)

have received a copy of this office's Notice of Privacy Practices. (You may keep page 6 of this application.)

Signature:_____

Date: _____

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

___Individual refused to sign

___Communications barriers prohibited the acknowledgement

___An emergency situation prevented us from obtaining

This Ronald McDonald Care Mobile® is made possible by a grant from Ronald McDonald House Charities®, Inc. ("RMHC®"); and ongoing financial support from Ronald McDonald House Charities of the Ozarks, Inc. ("RMHC of the Ozarks"). RMHC and RMHC of the Ozarks are non-profit, tax-exempt charitable corporations. RMHC and RMHC of the Ozarks have no responsibility or liability for the operation of this Ronald McDonald Care Mobile or any of the medical or dental activities conducted herein.

RMHC of the Ozarks

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.)