NYU | DENTISTRY

NYC Department of Education Mobile Oral Health Clinic Program
School Parental Consent Form

_____ *School(s) Covered*

New York University College of Dentistry Mobile Clinic Program *(MOHCP)**

345 East 24th Street, New York, NY 10010 *(MOHCP Address)**

Office Use Only

STUDENT INFORMATION:

Student Last Name: _____

Student First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Student Social Security #: _____

Sex: ☐ Male ☐ Female Grade: _____

Ethnicity: ☐ Hispanic ☐ Black ☐ White ☐ American Indian ☐ Asian/Pacific Islander ☐ Other: _____

Student Address: _____

_____

_____ _____ _____
City State Zip

Does your child have any medical history that may complicate dental treatment: ☐ No ☐ Yes (explain below)

_____

_____

_____

PARENT/GUARDIAN INFORMATION:

Mother

Last Name: _____ First Name: _____

Father

Last Name: _____ First Name: _____

Legal Guardian, If Applicable

Last Name: _____ First Name: _____

Relationship of legal guardian to student:

☐ Grandparent ☐ Aunt or Uncle ☐ Other: _____

Contact information for parent or guardian

Home Tel: _____ Work Tel: _____

Beeper/Cell: _____

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Beeper/Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid?

☐ No ☐ Yes: Medicaid ID #: _____

Does your child have Child Health Plus?

☐ No ☐ Yes: CHP #: _____

Which Plan?

☐ Affinity ☐ Fidelis
☐ Healthfirst ☐ Health Plus Amerigroup
☐ HIP ☐ MetroPlus
☐ WellCare ☐ United HealthCare

Does your child have dental coverage through your employer or any other type of dental insurance?

☐ No ☐ Yes: Dental Plan: _____

Member ID Number: _____

If your child does not have dental insurance, would you like an In-Person Assistor authorized by the NY State of Health Marketplace to contact you to enroll into dental insurance?

☐ No ☐ Yes: What is the best time to contact you?

_____

PARENTAL CONSENT FOR MOBILE ORAL HEALTH CLINIC SERVICES

I have read and understand the services listed on the next page (Mobile Oral Health Clinic Services) and my signature provides consent for my child to receive services provided by the New York University College of Dentistry Mobile Oral Health Clinic.

NOTE: By law, parental consent is not required for students who are 18 years or older or for students who are parents or are legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____ _____

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release oral health information as specified.

X _____ _____

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT.

NYC Department of Education Mobile Oral Health Clinic Program
School Parental Consent Form

_____ *School(s) Covered*

New York University College of Dentistry Mobile Clinic Program *(MOHCP)**

345 East 24th Street, New York, NY 10010 *(MOHCP Address)**

MOBILE ORAL HEALTH CLINIC SERVICES

I consent for my child to receive oral health care services provided under the supervision of State-licensed health professionals of New York University College of Dentistry as part of the mobile oral health program approved by the New York State Department of Health. I understand that confidentiality between the student and the oral health clinic provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and oral care decisions. Mobile Oral Health Clinic Services may include, but are not limited to, preventative oral health services, restorative oral health services, and emergency procedures that range from comprehensive dental exams, dental hygiene treatments, fluoride treatments, sealants, fillings and extractions.

NEW YORK CITY DEPARTMENT OF EDUCATION'S
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF MOBILE ORAL HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF MOBILE ORAL HEALTH INFORMATION

My signature on the reverse side of this form authorizes release of oral health information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing oral health information to be given to the Board of Education of the City of New York (a/k/a New York City Department of Education), either because it is required by law or by Chancellor's regulation, or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this oral health information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's oral health information, and that I can change my mind at any time and revoke my authorization by writing to the Mobile Oral Health Clinic. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize New York University College of Dentistry Mobile Oral Health Clinic to release specific oral health information of the student named on the reverse page to the Board of Education of the City of New York (a/k/a New York City Department of Education).

I consent to the release from the Mobile Oral Health Clinic to the NYC Department of Education and from the NYC Department of Education to the Mobile Oral Health Clinic, of oral health information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law and Chancellor's Regulations on confidentiality:

Information to Protect Health and Safety:
- Conditions which may require emergency
- Conditions which limit a student's daily activity (Form 103S)
- Diagnosis of certain communicable diseases (not including HIV infections/STI and other confidential services protected by law).
- Health insurance coverage

My signature on page 1 of this form also gives my consent to New York University College of Dentistry to contact other providers that have examined my child and to obtain insurance information.

Time Period During Which Release of Information Is Authorized:
From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the School-Based Oral Health Clinic

*MOHCP = Mobile Oral Health Clinic Provider

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT.

NYU | DENTISTRY

PEDIATRIC DENTISTRY SPECIALTY SERVICES

NYU College of Dentistry
345 East 24th Street, 9th floor
Clinic 9W
New York, NY 10010
P: 212 998 9650
F: 995 995 4242
http://dental.nyu.edu

Smiling Faces, Going Places
Mobile Dental Care Program

Travel History Questions

The New York State Department of Health has requested that we ask the following question(s) concerning recent travel history:

Has your child lived in, or traveled to, a country with widespread or limited Ebola virus transmission (Liberia, Sierra Leone, Guinea); or had direct contact with (or is living with) an individual with confirmed Ebola Virus Disease within the past 21 days?

_____ Yes _____ No

If yes, please answer the following questions:

Does your child have any of the following symptoms? (Please check all that apply)

_____ fever

_____ diarrhea

_____ abdominal complaints

_____ weight loss

_____ bleeding

_____ night sweats

_____ skin lesions/rashes

_____ pulmonary complaints

The College of Dentistry follows the recommendations of the Centers for Disease Control and Prevention (CDC) and the New York State Department of Health (NYSDOH) for safe infection control practices, which ensure keeping our patients and staff safe. The CDC and the NYSDOH advise individuals to stay home when they are sick and avoid contact with other people as much as possible to keep from spreading illness to others.

If your child has any of the above symptoms, please immediately contact your health care provider for further advice; and be advised that the New York University College of Dentistry Mobile Dental Care Program will not be able to provide dental care to your child at this time.

_____ _____

Print Name of Child Print Name of Parent or Guardian

_____

Signature of Parent or Guardian

_____

Date

NYU | DENTISTRY

Outreach Medical History

Chart #:

1. Child's Name *(Nombre del* niño): _____

2. Sex (*Sexo*): ☐ Male (*Masculino*) ☐ Female (*Femenino*) 3. Birthdate (*Fecha de nacimiento*): _____

4. Address *(Direccion)*: _____ 5. City (Ciudad): _____

6. Zip Code *(Código Postal)*: _____ 7. Telephone *(Telephono)*: _____

8. What is the language most spoken at home? (¿Cuál es el idioma más hablado en el hogar?) ☐ English (Inglés) ☐ Spanish (Español) ☐ Other (Otro): _____

9. Where was your child born? (¿Dónde nació su hijo?): ☐ United States (Estados Unidos) ☐ Other country (Otro país): _____

10. Race/Ethnicity (Check all that apply): Raza/Etnia (Marque todas las que corresponden) ☐ Caucasian (Caucásico) ☐ African American (Afroamericano) ☐ Hispanic/Latino (Hispano/Latino) ☐ Asian (Asiático) ☐ Other (Otro): _____

11. Is your child up to date on immunizations? (¿Está su hijo(a) al día con sus vacunas?) ☐ Yes (*Si*) ☐ No (*No*)

12. Is your child taking any medicine? (¿Toma su hijo(a) actualmente algún medicamento?) ☐ Yes (*Si*) ☐ No (*No*)
If yes, please list (Si contestó SÍ, sírvase indicarlo): _____

13. Has your child been hospitalized? (¿Ha sido hospitalizado a su hijo(a)?) ☐ Yes (*Si*) ☐ No (*No*)
Date (Fecha): _____ Reason (Razón): _____

14. Does your child have any of the following? (¿Su hijo(a) tiene alguna de las siguientes?):

Allergies (*ex: drug, food, latex*) (Alergias (*ex: droga, comida, látex*)) ☐ Yes (*Si*) ☐ No (*No*)
To (a): _____
Reaction (*ex. hives, throat swelling*) (Reacción) (ex. *urticaria, hinchazón de la garganta*): _____

Asthma (Asma) ☐ Yes (*Si*) ☐ No (*No*)
Date of Last Attack (Fecha del último ataque): _____ Trigger (Que lo causa): _____

Heart Problems (Problemas del corazón) ☐ Yes (*Si*) ☐ No (*No*)
Specify (Especificar): _____

Anemia/Bleeding Problems (Anemia/Problemas de hemorragias) ☐ Yes (*Si*) ☐ No (*No*)
Specify (Especificar): _____

Seizures (Convulsiones) ☐ Yes (*Si*) ☐ No (*No*)
Type (Tipo): _____ Trigger (Que lo causa): _____ Last episode (Último episodio): _____

Tuberculosis/Persistent coughing for 3+ weeks with chills and night sweats
(Tos persistente durante 3 semanas con escalofríos y sudores nocturnos) ☐ Yes (*Si*) ☐ No (*No*)
Date (Fecha): _____ Outcome (Resultado): _____

Hepatitis ☐ Yes (*Si*) ☐ No (*No*)
Type (Tipo): _____

HIV+/AIDS (El virus de immunodeficiencia humana VIH) ☐ Yes (*Si*) ☐ No (*No*)

Currently Pregnant (Embarazada) ☐ Yes (*Si*) ☐ No (*No*)

Other (Otra) ☐ Yes (*Si*) ☐ No (*No*)
Specify (Especificar): _____

15. Does your child have any developmental/behavioral problems (¿Tiene su hijo problemas de desarrollo o comportamiento?) ☐ Yes (*Si*) ☐ No (*No*)
If Yes, check all that apply (Si contestó SÍ, marque todos los que aplican):
☐ Developmental Delay (Desarollo retrasado) ☐ ADHD/ADD (TDAH) ☐ Autism (Autismo) ☐ Other (Otra) _____

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Outreach Medical History

Chart #:

16. Is this your child's first visit to the dentist? ☐ Yes (*Si*) ☐ No (*No*)
(¿Es esta la primera visita de su hijo al dentista?)

17. Does your child currently brush with toothpaste that contains fluoride? ☐ Yes (*Si*) ☐ No (*No*)
(¿Actualmente, su hijo se está cepillando con una pasta de dientes que contenga fluoruro?)

18. Who typically brushes your child's teeth? ☐ Child doesn't usually brush (Niño no suele cepillar) ☐ Child (Niño)
(Quién típicamente cepilla los dientes del niño?) ☐ Adult (Adulto) ☐ Child and Adult (Niño y Adulto)

19. In general, how would you describe your child's oral health? ☐ Excellent (Excelente) ☐ Good (Bueno)
(En general, ¿cómo describiría la salud oral de su hijo?) ☐ Not Very Good (No muy buena) ☐ Poor (Pobre)

20. Has your child recently complained of pain from a cavity? ☐ Yes (*Si*) ☐ No (*No*)
(¿Recientemente, su hijo se ha quejado de dolor por una carie?)

21. Does your child have any oral habits? (¿Su hijo tiene algún hábito oral?) ☐ Yes (*Si*) ☐ No (*No*)
If Yes, check all that apply (Si contestó SÍ, marque todos los que aplican):
☐ Bottle to bed (Botella a la cama) ☐ Thumb/finger sucking (Chuparse el dedo) ☐ Pacifier (Chupete) ☐ Sippy Cup (Vaso de bebé)
☐ Nail/object biting (Morderse las uñas u objetos) ☐ Teeth grinding (Rechinar los dientes)

Permission to Board the Dental Van

Formulario qu permita subir la camioneta dental

Name of Child *(Nombre de hijo/a)*

Print Name of Parent or Guardian
(Escribir el nombre del padre/madre o tutor en letras de imprenta)

I grant permission for my child to be taken out of his/her classroom to board the New York University College of Dentistry van for the purpose of dental treatment.*

*Otorgo permiso para que se saque a mi hijo(a) de su aula para subir a a camioneta del Colegio de Odontologia de la Universidad de Nueva York con fines de tratamiento dental.**

Signature of Parent or Guardian
(Firma del padre/madre o tutor)

Consent to Examination and Treatment – *Pediatric Patients*

At New York University (NYU) College of Dentistry, diagnosis and treatment is provided by dental students under the supervision of College of Dentistry faculty. The examination and diagnosis that will determine the proper dental care may require considerable time. I understand that it is my responsibility to inform the New York University College of Dentistry of any information concerning my child's health or physical or mental conditions that may be relevant to his or her care.

I hereby authorize, and voluntarily consent to the dental care and treatment of my child by NYU College of Dentistry, including routine diagnostic and therapeutic procedures and treatment and other treatments or procedures which are deemed necessary or advisable during the course of the treatment performed. I have been advised of the nature of the dental services to be provided. I agree to be contacted about programs that may improve my child's oral health. I acknowledge that no guarantees have been, or can be, made to me as to the result of the dental services provided.

Payment and Release of Information

I understand that I am financially responsible to NYU College of Dentistry for charges not paid by insurance or other third-party payors, unless otherwise prohibited by state or federal regulations or prohibited pursuant to the terms of any contract between New York University College of Dentistry and my financial sponsor. I authorize and request all third parties responsible for any portion of my bill to make payment directly to the College of Dentistry. I understand that it is my responsibility to obtain all pre-authorization and to comply with all requirements of my insurance on which I am relying for coverage of College of Dentistry charges.

I authorize NYU College of Dentistry, my treating providers and their respective designees to use and disclose my health information for treatment, payment, and healthcare purposes, including but not limited to, the release of information to my financial sponsor (including government units such as the New York City Department of Health and Mental Hygiene) or insurance company as may be required for payment to be made to my account for services rendered.

I have read and understand this Pediatric Consent. All of my questions have been answered.

Consentimiento Para Examen y Trato De Pacientes Pediátricos

En el Colegio de Odontología de la Universidad de Nueva York, el diagnóstico y el tratamiento son suministrados por los estudiantes de odontología bajo la supervisión de la facultad dental de la Universidad de Nueva York. El exámen y diagnóstico determinará el cuidado dental que su hijo o hija necesite y puede requerir un tiempo considerable. Yo entiendo que es mi responsabilidad notificarle a el Colegio de Odontología de la Universidad de Nueva York, cualquier información con respecto a la salud de mi hijo o hija ya sea físico o mental que podría ser relevante para su cuidado.

Por el presente autorizo y voluntariamente doy consentimiento para el cuidado dental y el tratamiento de mi hijo o hija por el Colegio de Odontología de la Universidad de Nueva York, incluyendo el diagnóstico de rutina y procedimiento terapeúticos y tratamientos o procedimientos que sean necesarios o aconsejables durante el curso del tratamiento o practicado. He sido informado de la naturaleza de los servicios dentales que serán suministrados. Doy consentimiento a ser contactado sobre los programas que ayudarán a mejor la salud bucal de mi hijo o hija. Reconozco que no se me ha dado, ni se dará ninguna garantía sobre los resultados de los servicios dentales suministrados.

Pago y liberación de información

Entiendo que soy económicamente responsable a el Colegio de Odontología de la Universidad de Nueva York por los cargos que no han sido pagados por el seguro, a menos que sea prohibido por regulaciones estatales o federales o prohibido por la conformidad con los términos de cualquier contrato entre el Colegio de Odontología de la Universidad de Nueva York y cualquier patrocinador financiero. Yo autorizo y solicito a todas las terceras partes responsables de cualquier parte de mi factura de efectuar el pago directamente a el Colegio de Odontología de la Universidad de Nueva York. Entendido que es mí responsabilidad obtener todas las pre-autorizaciones y cumplir con todos los requisitos de mi seguro en el que estoy depeniendo para la cobertura de los cargos de el Colegio de Odontología de la Universidad de Nueva York.

Autorizo a el Colegio de Odontología de la Universidad de Nueva York, mis proveedores de tratamiento y sus respectivos designad a usar y divulgar mi información médica para el tratamiento, pago y propósitos de la salud, incluyendo pero no limitado a, la publicación de información a mi patrocinador financiero (incluyendo unidades gubernamentales como El Departamento de la Salud e Higiene Mental de la Ciudad de Nueva York) o compañías de seguros que podrá ser utilizado para pagos a mi cuenta, por servicios suministrados.

He leído y comprendo este Constentimiento Pediátrico. Todas mis preguntas han sido contestadas.

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New York University College of Dentistry
Pediatric Dentistry Specialty Services
345 East 24th Street, 9th floor
New York, NY 10010
Phone: (212) 998-9650
Fax: (212) 995-4242

I hereby certify that I understand the nature of the above consent, which has been fully explained to me. I designate New York University College of Dentistry to be my child's primary care dentist.

Por el presente certifico que entiendo la naturaleza del consentimiento indicado anteriormente, el cual me ha sido explicado completamente. Designo al Colegio de Odontología de la Universidad de Nueva York como proveedor principal de cuidados dentales de mi hijo.

Parent/Guardian Signature: _____
Firma del padre/madre o tutor

Date: _____
Fecha

Child's Name: _____
Nombre del niño

Date of Birth: ____/____/____ Sex: Female / Male
Fecha de nacimiento *Sexo: Feminina / Masculino*

Address: _____
Direccion

_____

Telephone: (_____) _____
No. de telefono

For office use only: Chart # _____