SMILES TO GO

We Bring Our Dental Team To You!

Dentists R Us

Coming to your school

THIS FORM MUST BE FILLED OUT IN ORDER TO PARTICIPATE IN OUR INITIAL DENTAL SERVICE AND 6-MONTH FOLLOWUP

PARENTS/GUARDIAN

Dental services are provided by Licensed Dentists and Hygienists at your child's school. Dental treatment may include an Oral Exam, Cleaning, Fluoride, Sealants and necessary X-Rays. AN ORAL HEALTH REPORT and FREE TOOTHBRUSH will be provided to each child.

Patient (Student) Information (Please Print)

School Name:_____ **Teacher:**_____ **Grade:**_____

Student Name:_____ **Date of Birth:**_____ **Gender:** _____

Home Address:_____ **City:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____ **Date Of Last Dental Cleaning:**_____

HEALTH HISTORY - IMPORTANT. MUST BE FILLED OUT COMPLETELY

Has your child had any history of, or conditions related to, ANY of the following? Check ALL that apply:

☐ **Anemia** ☐ **Asthma/Emphysema** ☐ **Cancer** ☐ **Bleeding Disorder** ☐ **Cerebral Palsy** ☐ **Diabetes** ☐ **Fainting/Epilepsy/Seizures**

☐ **Kidney Disease** ☐ **Congenital Heart Disease** ☐ **Heart Murmur** ☐ **Latex Allergy** ☐ **Growth Problems** ☐ **Tobacco/ Drug Use** ☐ **Pregnancy**

☐ **HIV/AIDS** ☐ **Liver Disease/Hepatitis** ☐ **Thyroid Disease** ☐ **Joint Replacement** ☐ **Tuberculosis** ☐ **Allergies**_____

☐ **Other:**_____ **Need pre-medication before treatment? (Y / N) Please List Medications:** _____

DENTAL INSURANCE INFORMATION

☐ **My child has MEDICAID/MI CHILD (covers 100% of cost) Medicaid ID Number:**

Social Security Number (for billing purposes only):

___ ___ ___ - ___ ___ - ___ ___ ___ ___

☐ **My child has private dental insurance**

Name of Dental Insurance _____

Phone Number _____

ID# _____

Name of Parent under whom child is covered _____

Date of Birth of Insured Adult _____

Social Security Number of Insured Adult _____

Please note: HMO policies are not accepted

Dentists R Us will provide a 6-month recall visit for participating schools.

You will be receiving a reminder call prior to our return visit. If you do not wish to have your child seen, please contact our office before the visit.

The American Academy of Pediatric Dentistry (AAPD) recommends children visit the dentists at least every six months (twice a year).

IF NO DENTAL INSURANCE CHECK THE BOX THAT BEST APPLIES TO YOU

☐ **(I am unable to pay FULL FEE)** I will pay **a Reduced Fee of $35.00 (CHECK PAYABLE TO HEALTHY SMILES)** for cleaning, exam, fluoride, due to financial hardship, and will sign **Reduced Fee Waiver: Parent/Guardian**_____

☐ Financial Hardship- I have **NO** dental Insurance/ Medicaid. Please call for assistance at **(248)268-2093**

FOLLOW-UP CARE

- An oral health report will be sent home after every visit indicating any necessary follow-up treatments (fillings, extractions, etc.).
- **Follow-up treatment is available at our dental office: 38865 Dequindre Rd. Suite #105 Troy, MI (248) 879-7755**
- X-Rays and reports can be sent to the dental office of your choice.

I (Parent/ Legal Guardian) give Dentists R US/Healthy Smiles permission to perform an initial oral exam, cleaning, fluoride, sealants, necessary X-Rays, and a 6-month check-up (cleaning, fluoride, sealants) on my child; I understand that these services may occasionally cause minor discomfort upon completion. I authorize and request my insurance company to pay Dentists R Us on my behalf. I understand that I am responsible for any deductibles and copays from my private insurance. I understand that treatment may be obtained at patient's dental home rather than mobile dental facility, and that obtaining duplicate services at a mobile facility may affect benefits that he/she receives from a private insurance, a state or federal program, or other third-party provider of dental benefit. I have reviewed Notice of Privacy Practice (HIPPA), on the back of this form. I authorize the school nurse/staff, and/or dentist of my preference to obtain my child's dental records. Please take oral health report to child's present provider if additional dental services are needed. Call our office for more information and questions. I certify that I have read and understood the above information to the best of my knowledge.

PARENT/ GUARDIAN SIGNATURE (REQUIRED) _____ **Date:** _____

Dentist's Initials_____ **Hygienist/Staff Initials**_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information

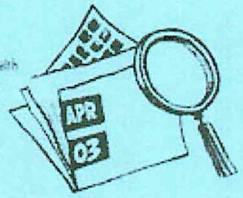
Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information



You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

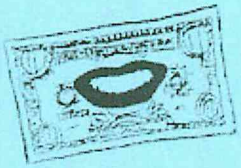
You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

How your HEALTH INFORMATION may be used

To Provide Treatment

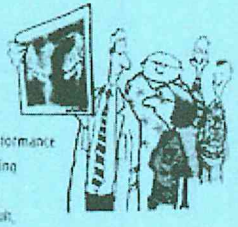
We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

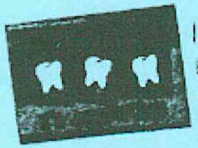


We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations



Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.



In Patient Reminders

because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Dentists R US
53 W Maple
Clawson MI, 48017
www.dentistrus.com
Emergency (24-Hour Service) - (248) 268-2093
We Bring Our Dental Team To You!

Darshika Shah, DDS
Sheretta Oates, DDS