



mosaic health
Community Dentistry

Portable Dental Services Coming to Your Child's School !!

**No need for you to miss work or for your child to miss school.
Services provided on site during the school day.**

**If you would like your child to participate in the program
make sure you completely fill out the registration packet, sign and
return to your child's teacher.**

Services we can provide:

Dental Screening

Oral Health Education

Oral Exam by a Dentist

Dental Cleanings

Check-up X-Rays

(2-4 x-rays that determine if there are cavities in between the teeth or under existing fillings that cannot be seen visually)

Fluoride Treatments

(Up to 2 times per school year and will be applied every 3 months during the school year for students ages 6 and younger)

Dental Sealant(s)

(A thin material applied to the pits and grooves on the chewing surface of the adult molars that help to protect the teeth from cavities)

Referrals if Needed

Questions please call: (585) 243-7847

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Student's Name: _____ Date of Birth: ___ / ___ / _____ Male Female

School: _____ Grade: _____ Teacher: _____

My child has **NEVER** seen a dentist

My child's dentist is:

Dentist Name: _____ Phone: _____ - _____ - _____

Address: _____

Has your child seen the dentist in school before? YES NO

*Please note: Your child's dentist **will be** notified of the dental services provided through his/her participation in the dental program.

Race/Ethnicity (for tracking purposes only) check below:

White/Caucasian Black/African American Native American

Other Pacific Islander Asian

Non-Hispanic Hispanic

Student's Primary Language: _____

Does the student need an interpreter? YES NO

Consent to Participate

YES, I give permission for my child to participate in the program
(Please sign below and complete the entire packet and return in the attached envelope)

NO, I do not give permission for my child to participate in the program
(Please sign below and STOP)

Signature of Parent or Legal Guardian

Printed Name of Parent or Legal Guardian

Relationship to the Child

Today's Date



Student's Name: _____ Date of Birth: ___ / ___ / _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ - _____ - _____ Phone #: _____ - _____ - _____

School: _____ Grade: _____ Teacher: _____

Services: (Current School Year Only)

Students enrolled in this program will receive **free education** and a **dental screening**

Please **CHECK** below for additional services you are choosing for your child:

Cleaning with a fluoride treatment (may be up to 2 times per school year, additional fluoride will be applied every 3 months during the school year for students ages 6 and younger) **x-rays**, as needed, by a hygienist followed by an **exam** by a dentist, and **dental sealants** if needed (see cover letter for description)

We will provide dental service(s) without you being present.

If you wish to join your child during their dental visit, please check mark the box and we will contact you for an appointment time. If you are unreachable your child will be seen without you.

Parent/Guardian Information

Mother's Name: _____ **Email:** _____

Phone #: (H) _____ - _____ - _____ (C) _____ - _____ - _____ (W) _____ - _____ - _____

Father's Name: _____ **Email:** _____

Phone #: (H) _____ - _____ - _____ (C) _____ - _____ - _____ (W) _____ - _____ - _____

Guardian's Name: _____ **Email:** _____

Phone #: (H) _____ - _____ - _____ (C) _____ - _____ - _____ (W) _____ - _____ - _____

Emergency Contact Information

(Please list someone other than the parent/guardian)

Contact Person's Name: _____ **Relationship to child:** _____

Phone #: (H) _____ - _____ - _____ (C) _____ - _____ - _____ (W) _____ - _____ - _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____



Financial

In order for Mosaic Health to help patients without insurance coverage **we must** ask you to complete the following information. This is requested of you so Mosaic Health can receive Federal grant dollars to serve those patients. We appreciate your cooperation. **All information is kept confidential and is used for reporting purposes only.**

Total Number of people in your household (include everyone): _____

Total Household income: (Please check the amount that best describes the total income in your household)

- | | | |
|---|--|--|
| <input type="checkbox"/> Less than \$11,000 | <input type="checkbox"/> \$30,001-\$35,000 | <input type="checkbox"/> \$55,001-\$60,000 |
| <input type="checkbox"/> \$11,001-\$15,000 | <input type="checkbox"/> \$35,001-\$40,000 | <input type="checkbox"/> \$60,001-\$65,000 |
| <input type="checkbox"/> \$15,001-\$20,000 | <input type="checkbox"/> \$40,001-\$45,000 | <input type="checkbox"/> \$65,001-\$70,000 |
| <input type="checkbox"/> \$20,001-\$25,000 | <input type="checkbox"/> \$45,001-\$50,000 | <input type="checkbox"/> \$70,001-\$75,000 |
| <input type="checkbox"/> \$25,001-\$30,000 | <input type="checkbox"/> \$50,001-\$55,000 | <input type="checkbox"/> Greater than \$75,001 |

Financial Assistance: Based on the information in household income above, you and your family may be eligible for Mosaic Health’s Sliding Fee Scale Discount Program. A staff member may be contacting you for follow-up.

Dental Insurance Information

UNINSURED for DENTAL COVERAGE

MEDICAID INSURANCE ID# _____
(2 letters, 5#’s, 1 letter-ex. AB12345C)

OTHER DENTAL INSURANCE ID# _____ **GROUP#** _____

PLAN NAME: _____ INSURANCE PHONE#: _____

INSURANCE COMPANY STREET ADDRESS: _____

POLICY HOLDER NAME: _____ DOB: ___ / ___ / _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ EMPLOYER: _____

Responsible Party

Name: _____ Date of Birth: ___ / ___ / _____

Phone #: _____ - _____ - _____ Social Security Number: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Child: _____

If you require assistance with completion of this form or have any questions, please call **(585) 243-7840 ext. 7604**



Does Your Child Currently Have or Has Previously Had Any of the Following Medical Conditions?

(Please circle YES or NO for each condition listed)

ADHD/ADD	YES	NO	Heart Trouble (murmur, prosthesis)	YES	NO
Allergy to Latex	YES	NO	High Blood Pressure	YES	NO
Artificial Joints	YES	NO	Kidney Disease or Trouble	YES	NO
Asthma	YES	NO	Low Blood Pressure	YES	NO
Autism	YES	NO	Pregnancy (Due Date: _____)	YES	NO
Blood Disorder/Anemia	YES	NO	Seizures or Epilepsy	YES	NO
Cancer	YES	NO	Tuberculosis (TB)	YES	NO
Diabetes	YES	NO	Other: _____	YES	NO

If **Yes** to any question above, please explain: _____

Does your child **have any allergies**? YES NO

Please List Allergies: _____

Has your child had **any major surgeries**? YES NO

Please List Types and Dates: _____

Has your child had any **overnight hospitalizations** in the **past 3 years**? YES NO

Please List Reason and Dates: _____

Does your child **take any medications** on a DAILY basis? YES NO

Please List Medications/Dosage: _____

Do you have any concerns regarding your **child's dental health**? YES NO

Please explain: _____

What is the **source** of your **child's water**? Town/City Bottled Well

Medical Provider Information

Does your child have a **Medical Provider** (Doctor, Nurse Practitioner, or Physician Assistant)? YES NO

Name of Provider: _____ Phone # _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy Information

Name of Pharmacy: _____ Phone #: _____ - _____ - _____

Address/Location: _____ City: _____ Zip: _____

If you require assistance with completion of this form or have any questions, please call **(585) 243-7840 ext. 7604**



CONSENT

In order for us to treat your child, you must sign below indicating you have read and agree to the following information:

Authorization for Treatment:

I, the undersigned, the parent or legal guardian of the above named child, hereby authorizes the dental staff of Mosaic Health to provide dental care as indicated to my child in his/her school. **It is the parent/guardian(s) responsibility to inform the dental provider of any changes in their child's medical information by calling (585) 325-2280 Extension 7604.**

Financial Responsibility/Assignment of Benefits:

I authorize Mosaic Health to apply for benefits on my behalf to my child's insurance carrier and request my child's insurance company pay directly to Mosaic Health. insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify Mosaic Health of any changes. ***If your child has had a dental cleaning within the past 6 months and you have used your insurance, he/she is not eligible for insurance reimbursement at this time.*** If your insurance covers partial payment or denies services you may be billed for services. The following services and fees may be billable: dental cleaning with a fluoride treatment is \$115 (ages 0-6), dental cleaning with a fluoride treatment is \$97 (ages 7-12), dental cleaning with a fluoride treatment is \$125 (ages 13+), pediatric exam (ages 0-3) is \$73, initial dental exam is \$83, recall patient exam is \$47, two bitewing radiographs are \$44, four bitewing radiographs are \$63, a single radiograph is \$27 and sealants are \$52 per tooth. ***No child will be denied services due to inability to pay, please call for assistance.***

Release of Information:

If my child's health history indicates health problems which may affect his/her dental treatment or if proof of legal guardianship is needed, I consent to having my child's medical doctor/dentist/school release my child's medical/dental/guardianship information to the Mosaic Health dental staff.
If a dentist is noted above, I understand that any dental findings/treatment shall be forwarded to that provider. I also give consent for Mosaic Health to provide my child's school nurse with a dental health certificate, if requested.

******Forms that do not have a parent/guardian's signature will be returned******

Childs Name: _____

Date of Birth: ___ / ___ / _____

Signature of Parent or Legal Guardian

Printed Name of Parent or Legal Guardian

Relationship to the Child

Today's Date