School of Dental Medicine

S-Miles To Go Mobile Dental Program

UB's ***S-MILES TO GO DENTAL PROGRAM*** will be visiting your child's school soon. If you do not have a dentist this is a great opportunity for your child to receive dental care during the school day.

WHAT IS IT?

UB ***S-MILES TO GO DENTAL PROGRAM*** (Dental Van)offers the following dental services to your children:

- A new 3 chair mobile dental office that will be parked at the school
- Examinations, x-rays, cleanings, sealants, fillings and other dental services
- Specially trained Pediatric and General Dentists
- If your child has dental insurance, the insurance carrier will be billed for these services described above. If you do not have dental insurance or cannot afford dental care, we have a sliding fee program to assist you. Our goal is to provide dental services to all regardless of ability to pay. Please call 716-829-6240 for information on the Sliding Fee Program.

HOW DOES IT WORK?

- Complete the attached consent form. Please include insurance information and check just one box indicating the services you wish your child to receive. Don't forget to sign the form.
- Medicaid, Child Health Plus and Family Health Plus Insurances will be billed for services and are accepted as payment in full.
- Dental screening and oral health education are provided at no charge to you and a screening report form will be sent home.
- Treatment is provided to your child during the school day on the *S-Miles To Go* unit or in the school with portable dental equipment.
- Parents are welcome to attend the appointment but it is not necessary.

WHAT'S NEXT?

⬭ **YES, I want my child to receive dental care**

If yes, to sign your child up for the S-miles To Go mobile dental program please complete the attached paperwork and return it to your child's teacher as soon as possible.

⬭ **NO, I do not want my child to receive dental care, my child sees a dentist regularly.**

Child's Name: _____Grade_____Teacher_____

If No, Please return this form to your child's teacher to avoid further communication. Thank You!

QUESTIONS?

- Contact Paula Fischer at UB at 716-829-6240 or pmfische@buffalo.edu

Poor oral health can lead to decreased school performance, poor social relationships and less success later in life. Children experiencing oral pain are distracted and unable to concentrate on schoolwork. UB Dental is here to help your child succeed.

School of Dental Medicine

S-Miles To Go Mobile Dental Program

PATIENT INFORMATION		DATE:	
Child's Name:	Sex: M / F	**Birth Date:** / /	
Address:	City:	Zip Code:	
Phone:	**Child's Social Security Number:**		
Child's School:	Teacher's Name:	Grade:	
PARENT OR GUARDIAN INFORMATION			
Parent/Guardian Name:	Sex: M / F	**Birth Date:** / /	
Address:	City:	Zip Code:	
Social Security Number:	Home Phone:		
Work Phone:	Cell Phone:		

PLEASE ANSWER QUESTIONS BELOW BY CHECKING THE BOX

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Students Primary **Language is:**	Does the student need an interpreter? ☐ Yes ☐ No

HEALTH INFORMATION		
IS YOUR CHILD IN GOOD HEALTH?	☐ Yes	☐ No
If no, explain:		
NAME OF CHILD'S **Medical** Doctor:		
IS YOUR CHILD TAKING ANY MEDICATIONS?	☐ Yes	☐ No
If yes, list medications:		

IS THIS YOUR CHILD'S FIRST DENTAL VISIT?	☐ Yes	☐ No	☐ Not sure
If no, has it been over **6 months** since his/her last visit?		☐ Yes	☐ No
DOES YOUR CHILD HAVE ANY EXISTING DENTAL PROBLEMS/CONCERNS (toothache, loose tooth, swelling?)		☐ Yes	☐ No
If yes, explain:			

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?					
Heart Disease	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Blood Transfusions	☐ Yes	☐ No
Sickle Cell	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No	Prolonged Bleeding	☐ Yes	☐ No
Hepatitis / Liver	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Emotional disorder(s)	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Allergies **	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Other?	☐ Yes	☐ No	Speech or Hearing Impaired	☐ Yes	☐ No

**** Please list known allergies:**

UB Dental Provider's Signature: **OVER →**

CHILD'S PREVIOUS DENTIST IF ANY:

DENTAL CONSENT FORM: (IN ORDER FOR US TO TREAT YOUR CHILD, **YOU MUST SIGN ON THE NEXT PAGE** INDICATING YOU HAVE READ AND AGREE TO THE FOLLOWING INFORMATION)

IF YOU NEED ASSISTANCE COMPLETING THIS FORM PLEASE CALL SARAH AT 716-397-2640

Financial Responsibility/Assignment of Benefits:

I authorize The UB School of Dental Medicine (UBSDM) to apply for benefits on my behalf to my child's insurance carrier and request my child's insurance company pay directly to UBSDM insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify UBSDM 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. Medicaid, Child Health Plus, and Private Insurance will be *accepted as payment in full*. You will not receive a bill if we have the correct insurance information. In the event you feel you received a bill in error, please call 716-829-6240.**

Responsible Party: (This is the individual who is responsible for the payment of your child's bills)

Name: _____Date of Birth _____Social Security#_____

Mailing Address: _____City: _____State: _____

Zip Code: _____Phone Number: _____ Relationship to Child _____

○ **No,** my child **DOES NOT** have **dental** insurance (you will be contacted by program staff)

○ **Yes,** my child **HAS dental** Insurance (This information can be found on the dental insurance card that covers your child.)

Dental Insurance Name: _____ **ID Number:** _____
(Example: Medicaid, Fidelis, Your Care, Independent Health etc.) (Number is on the card)

CIN Number (Example: AB12345CD): _____**Sequence Number:** (Example: 02, 43, 69) _____

Please complete this section if your child has dental insurance through your Employer:

Private **Dental** Insurance Name (Example MetLife, Delta Dental, Guardian): _____

Subscriber/Enrollee ID: _____Group Number_____ Date of Birth_____

Group Name: _____ Employer: _____
Insurance Company Street Address:

_____City_____State_____Zip_____

Name of person who carries the insurance: _____Relationship to patient_____

DENTAL CONSENT FORM CONTINUED

- **I understand that by signing this form, I am consenting for the child named above to receive a dental examination, bitewing and/or panoramic x-rays as needed, dental cleaning, brushing / flossing instructions, fluoride treatment, sealants, fillings, crowns, extractions (teeth pulled) and pulpal therapy as needed. Questions? Give us a call 716-829-6240.**

- The risks associated with treatment are: accidental biting or scratching of the lip/cheek by the child if local anesthesia is used and /or slight discomfort, bleeding and /or swelling. If no treatment is provided, the following may occur: undetected dental/oral disease (cavities, gum disease etc.), which may lead to pain, swelling, and/or infection.

- In the highly unlikely event that either my child or a treating provider of my child is exposed to blood and/or potentially infectious bodily fluids during treatment, I consent to my child being transported immediately to a local hospital for medical evaluation and follow-up by a Physician or Health Care Provider. I understand that while every effort will be made to inform me prior to this occurring, I understand that due to the importance of timely evaluation, I consent to this evaluation and/or treatment absent my verbal consent after potential exposure.

- I understand that this consent will stay in effect for one school year. I understand that it is my responsibility to inform the dental provider and/or the school nurse of any changes in my child's medical information.

- I understand that all information about my child will be kept confidential. I have read and agree to the Notice of Privacy Practices.

  Notice of Privacy Practices:
  http://dental.buffalo.edu/content/dam/dental/Pictures/Patients/Patient%20Privacy%20Information/NPP%20v%201.5%2001-15%20Final.pdf

- If your child needs specialty care (sedation), you will be notified and referred to the UB School of Dental Medicine or a provider in your area.

- I further consent that my child's medical doctor and/or school official may release any medical information to the UB Dental staff that may affect his/her dental treatment. In addition, if a dentist is noted above, I understand that any dental findings/treatment shall be forwarded to that provider.

- Photographs may be taken for educational purposes. I hereby grant the University at Buffalo School of Dental Medicine permission to use the likeness of my child in a photograph or other digital reproduction in any and all of its publications, including website entries, without payment or any other consideration. **If No, check here** ☐

*****PLEASE CHECK ONE BOX ONLY*****

☐ Yes, I would like my child **to have a dental examination including x-rays (if needed), cleaning, fluoride treatment, sealants** (a coating that protects teeth from cavities), **fillings, extractions(teeth pulled) and other treatment as needed** by a licensed dental provider and/or dental student who is supervised by a licensed dental provide

OR

☐ Yes, I would like my child **to have a dental screening and oral health education (no charge to you)** by a licensed dental provider and/or dental student who is supervised by a licensed dental provider.

**** A report form will be sent home with your child****

By signing this form, I give consent for treatment and agree to the Financial Responsibilities previously listed.

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

Parent/Guardian Signature:

_____ **Date**__ __/__ __/ __ __

YOUR CHILD CANNOT BE SEEN FOR DENTAL CARE UNLESS THE ABOVE INFORMATION IS RECEIVED
If you need assistance completing this form please call Sarah at 716-397-2640

School of Dental Medicine

PLEASE NOTE: THIS DOCUMENT AND THE NOTICE OF PRIVACY PRACTICES ARE FOR YOUR INFORMATION ONLY AND SHOULD NOT BE RETURNED.

If you child has a dental emergency please call the Mobile Dental Van at 1-866-254-0052 or 716-560-5127. After hours or on the weekend, proceed to your nearest emergency care facility. The UB School of Dental Medicine is not responsible for reimbursement of any charges you incur while obtaining emergency dental care at any other facility. If you have any questions please contact Paula Fischer at (716) 829-6240 or Shirley Hammond at 716-969-1076.

Your child will be a registered patient of the UB School of Dental Medicine. The following are your rights and responsibilities as a patient.

YOU HAVE THE RIGHT, CONSISTENT WITH NEW YORK STATE LAW TO:

1. Understand and use these rights. If for any reason you do not understand or need help, the school will provide assistance;
2. Be treated with dignity and respect, regardless of your race, religion, age, disability, gender, beliefs, marital status, lifestyle, sexual orientation, national origin or sponsor;
3. Be informed of the services available at the clinic;
4. Be informed of the provisions for off-hour emergency coverage;
5. Receive treatment in a clean and safe environment, free of unnecessary restraints;
6. Receive emergency, incremental and total care to completion consistent with the standard of care in the profession;
7. Receive planned treatment with knowledge of anticipated cost, potential eligibility for third-party reimbursements and when applicable, the availability of free or reduced cost care;
8. Receive an itemized bill or statement of account, upon request;
9. Receive complete and current information about your diagnosis, treatment and prognosis in terms you can reasonably be expected to understand;
10. Receive education, counseling and explanations to your questions;
11. Know the names, positions and functions of any personnel involved with your care;
12. Participate in all decisions about your treatment;
13. Receive all the information that you need to give informed consent prior to the start of any non-emergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific treatment or procedure, the alternatives to care, the risk of no treatment, the reasonably foreseeable risks and benefits of the treatment and expected outcomes disclosed in manner permitting the patient to make a knowledgeable decision;
14. Refuse examination or treatment to the extent permitted by law and be fully informed of the medical consequences to your action;
15. Refuse to take part in experimental research. In deciding whether or not to participate, you have the right to a full explanation;
16. Access to a patient advocate;
17. Voice grievances and recommend changes in policies and services to University at Buffalo School of Dental Medicine staff, the operator and the New York State Department of Health without fear of reprisal;
18. Express complaints about the care and services provided and have University at Buffalo School of Dental Medicine staff investigate such complaints. The University at Buffalo

School of Dental Medicine is responsible for providing a written response within 30 days if requested indicating the findings of the investigation. If the patient is not satisfied, the patient may complain to the New York State Department of Health's Office of Primary Health Systems Management;

19. Privacy and confidentially of all information and records regarding your treatment;
20. Approve or refuse the release or disclosure of the contents of the medical record to any health-care practitioner and or health care facility except as required by law or third-party payment contract;
21. Access to your medical record per Section 18 of the Public Health Law, and Subpart 50-3;
22. Review your records with a clinician and obtain a copy of your record for which the School of Dental Medicine can charge a reasonable fee;
23. Designate family members and other adults as authorized representatives to disclose protected health information, upon written authorization. You have the right to impose limits on the disclosures and revoke the authorization at any time, as permitted by law according to the Notice of Privacy Practices;
24. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy.

YOU HAVE A RESPONSIBILITY TO:

1. Provide to the best of your knowledge, accurate and complete information about present medical and dental history, past illnesses, hospitalizations, medications, and other matter relating to your health. You have the responsibility to report changes in your health status;
2. Follow the treatment plan agreed upon by you and your dental care providers. This may include following instructions of allied dental health personnel as they carry out the coordinated plan;
3. Make known to your dental care provider that you understand and accept the treatment plan and that you know what is expected of you;
4. Comply with the rules and regulations of the UB School of Dental Medicine, The State University of New York at Buffalo, and the State of New York;
5. Be on time and available for your appointments (3-4 times per month);
6. Have a working phone number in order for your dental provider to be able to contact you to schedule appointments;
7. Be considerate and respectful of the rights of other patients and UB School of Dental Medicine personnel. You are responsible for being respectful of the property of other persons and the University at Buffalo. Patients are expected to treat UB faculty, students and staff with courtesy and respect. Inappropriate behavior or comments of a cultural, ethnic or sexual nature will not be tolerated;
8. Provide proper childcare while you are being treated at the SDM clinics. Children are not to be left unattended and are not permitted to accompany an adult patient who is receiving treatment;
9. Be escorted into patient treatment areas by your student dentist. No other individual should accompany you into the treatment areas unless medically necessary or approved by the student dentist's faculty;
10. Pay for service at the time it is provided.

Public Health Law (PHL) 2803 (1)(g)Patient's Rights,
10NYCRR,405.7,405.7(a)(1),405.7(c)