LAKESHORE community health care School Dental Program Patient Information

MRN: _____
Office Use Only

Has your child seen a dentist in the last 12 months? ☐ Yes* ☐ No **If you currently have a dentist, please continue care with them.*

☐ STOP **No, I do not give permission for my child to participate in the school dental program.** *We welcome all patients. If you have already established care with a dentist other than Lakeshore Community Health Care, we ask that you continue your care with them.*

☐ GO **Yes, I give permission for my child to participate in the school dental program.** I authorize Forward Health or my insurance company to be issued a claim for billable services. I understand that I may be billed for charges not covered by my co-pay or insurance and it is my responsibility to check this student's dental benefits.

Is your child currently a patient at Lakeshore Community Health Care? ☐ Yes ☐ No

Date:_____ Child's School:_____ Grade:_____

Child's First Name:_____ Middle Initial:____ Last Name:_____

Previous last name(s):_____

Social Security Number: _____ Date of Birth:_____

Legal Sex
- ☐ Female
- ☐ Male
- ☐ Nonbinary

Gender Identity
- ☐ Female
- ☐ Male
- ☐ Nonbinary
- ☐ Choose Not to Disclose
- ☐ Other
- ☐ Transgender Female
- ☐ Transgender Male

Sex Assigned at Birth
- ☐ Female
- ☐ Male
- ☐ Choose Not to Disclose

Sexual Orientation
- ☐ Straight
- ☐ Bisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Queer
- ☐ Something Else
- ☐ Choose Not to Disclose

Is the patient experiencing homelessness? ☐ Yes ☐ No

Patient's Address:_____ Apt/Lot #:_____

City:_____ State:_____ Zip code:_____

Phone Number:_____ ☐ Home ☐ Work ☐ Mobile Second Phone:_____ ☐ Home ☐ Work ☐ Mobile

Preferred Communication: ☐ Text* ☐ Call Email Address: _____

**Text message rates may apply.*

Emergency Contact Full Name:_____ Phone:_____

Relationship to Patient: _____ Legal Guardian: ☐ Yes ☐ No

Patient's Marital Status
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Legally Separated
- ☐ Married
- ☐ Other
- ☐ Significant Other
- ☐ Single
- ☐ Widowed
- ☐ Choose not to disclose

Ethnicity
- ☐ Not Hispanic or Latino/a
- ☐ Cuban
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Puerto Rican
- ☐ Other Hispanic, Latino/a or Spanish Origin
- ☐ Choose not to disclose

Race (Check all that apply)
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian/Chamorro
- ☐ Samoan
- ☐ White/Caucasian
- ☐ Choose not to disclose
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Veteran
- ☐ Yes
- ☒ No

Accessibility Assistance
- ☐ Wheelchair
- ☐ Hearing Impaired
- ☐ Speech Impaired
- ☐ Vision Impaired
- ☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other:_____

Interpreter Needed: ☐ Yes ☐ No

Patient's Employment Status

☐ Child ☐ Student ☐ Not Employed ☐ Part-Time ☐ Migrant/Seasonal

☐ Full-Time ☐ Active Military Duty ☐ Retired ☐ Self-Employed

Employer:_____

Who is legally and financially responsible for the patient's dental and medical decisions?

☐ Self ☐ Parent ☐ Kinship ☐ Guardian ☐ Power of Attorney ☐ Case Worker

Responsible Person's Information (PLEASE PRINT)

Full Name:_____ Legal Sex: ☐ Female ☐ Male ☐ Nonbinary

Social Security Number: _____ Date of Birth:_____

Address:_____ Apt/Lot #:_____ City:_____ State:___ Zip code:_____

Phone Number:_____ ☐ Home ☐ Mobile ☐ Work Email Address: _____

Relationship to Patient:_____

Employer: _____

Employment Status

☐ Full-Time ☐ Self-Employed ☐ Not Employed

☐ Part-Time ☐ Retired ☐ Seasonal ☐ Active Military Duty

If you are not the parent of the child, Please provide a copy of the custodial order documentation.
For example: Guardianship Order, POA Health Care Agent Designation, Medical Service Consent, etc.

INSURANCE

☐ **The patient does not have DENTAL insurance.**

☐ **The patient has DENTAL insurance, including State/BadgerCare.**

Policy Holder's Full Name: _____ Policy Holder's Date of Birth: _____

Name of Insurance Company: _____

Group/Policy #: _____ Member ID #: _____

If medication is needed, list your preferred Pharmacy with location:_____

Example: Walgreens Two Rivers, Walmart Sheboygan South

☐ **The patient does not have MEDICAL insurance.**

☐ **The patient has MEDICAL insurance, including State/BadgerCare.**

Policy Holder's Full Name: _____ Policy Holder's Date of Birth: _____

Name of Insurance Company: _____

Group/Policy #: _____ Member ID #: _____

Date of child's last medical exam: _____ Weight:_____Height:_____ MRN: _____

☐ Yes ☐ No Do you have concerns about this child's teeth or dental health? If yes, please explain: Office Use Only

_____

☐ Yes ☐ No Does your child take any medications? If yes, please list them:

_____

☐ Yes ☐ No Does your child have any allergies? If yes, please explain:

_____

☐ Yes ☐ No Has your child ever had any serious illnesses or operations? If yes, please explain:

_____

☐ Yes ☐ No Has a doctor told your child to take a pre-medication (antibiotic) before dental visits? If yes, explain:

_____

☐ Yes ☐ No Does your child have any medical conditions? **If yes, check the boxes below that apply**:

☐ Abuse as a child (victim)	☐ Broken Jaw	☐ Heart Endocarditis	☐ Nerve/muscle disease
☐ ADD/ADHD	☐ Cancer	☐ History of blood transfusion	☐ Pregnancy
☐ Allergies	☐ Depression	☐ HIV/AIDS	☐ Seizures
☐ Anemia	☐ Diabetes mellitus	☐ Liver disease	☐ Sickle cell anemia
☐ Anxiety	☐ Heart Disease	☐ Meningitis	☐ STD
☐ Asthma	☐ Heart Failure	☐ Mental Health Disorder	☐ Stomach ulcers
☐ Autism	☐ Heart Murmur	☐ MRSA History of Infection	☐ Stroke

Add dates of diagnosis and information about medical concerns below. *Example - last seizure or weeks pregnant:*

Authorization for Treatment

I do hereby acknowledge, agree and give my consent for dental diagnosis and treatment as deemed necessary by Lakeshore Community Health Care (LCHC) as indicated appropriate by my treating provider, their assistants and/or designees. This authorization includes, but is not limited to, routine procedures, x-rays, fluoride treatment, cleaning, sealants, fillings, anesthetic, Silver Diamine Fluoride, crowns*, root canals*, pulpotomies*, simple extractions* (*services for baby teeth only) and other tests or procedures. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or provider whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as result to examination and treatment received. I acknowledge that my care is under the direction of my treating provider and LCHC will follow the instructions of my provider(s) in the position in said care.

I understand that I am financially responsible to LCHC as the patient, guardian, and conservator or insured for all services not covered by insurance. Charges may include dental insurance deductibles, co-insurance and out-of-pocket expenses.

I acknowledge notification of LCHC's Privacy Practices and Patient Rights and Responsibilities. LCHC is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of LCHC, OCHIN supplies information technology, including LAKESHORE Health Connect and related services to LCHC and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by LCHC with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

I agree to have LCHC contact my medical physician to release medical information pertaining to my child's dental needs. I agree to the sharing of information between my child's school and the LCHC dental program. I understand that I may be billed for charges not covered by my co-pay or insurance. This authorization expires in one year from date below, unless revoked verbally or in writing.

_____ _____

Signature (Parent/Guardian/Legal Representative) **Date**

Silver Diamine Fluoride may be recommended to treat your child, especially younger children or children with high anxiety. Please review the following information, reach out to our school dental program coordinator with any questions, and sign and date at the bottom.

MRN: _____
Office Use Only

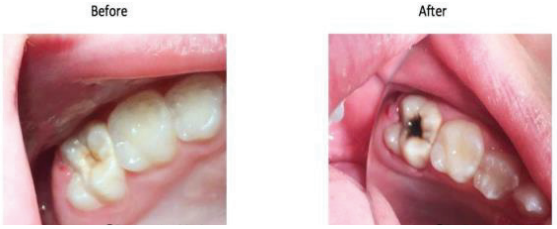
Silver Diamine Fluoride Treatment Consent: ☐ YES ☐ NO

Patient Name: _____ **Date of Birth:** _____

Silver Diamine Fluoride (SDF) is a liquid medication that is applied to an active area of decay (cavity) to kill the bacteria causing the cavity, prevent the formation of a plaque layer on the treated surface, and strengthen the tooth.

It is very important that you are made aware that treating cavities with this medicine will cause color changes to the lesions (cavity). The areas of the tooth with active dental decay will turn dark black as the medicine is working. The healthy areas of the tooth will not be affected and will remain your child's natural tooth color. The black color indicates that the treatment is successful.

Examples of teeth treated by Silver Diamine Fluoride.



- If Silver Diamine Fluoride comes in contact with skin/gums, temporary discoloration will occur.
- Silver Diamine Fluoride may discolor teeth that have tooth-colored (resin) restorations, as well as demineralized (soft) enamel.
- Patients that have allergies to certain metals, including silver, should NOT receive SDF.
- A 5% Sodium Fluoride varnish will be used to seal Silver Diamine Fluoride onto the teeth, as well as prevent other cavities.
- Patient may need multiple treatments of Silver Diamine Fluoride. No guarantee of results can be made.

It is important that you are aware that this medicine will treat the bacteria causing tooth destruction, but will not restore (fill) the tooth structure that has already been affected by the disease process. **You may still require restoration of the teeth (fillings, crowns and possibly nerve treatment) if there is any loss of tooth structure.** The timing of additional treatment will vary, and we will discuss the best way to provide this treatment to ensure that you receive treatment in the least invasive, most predictable and least traumatic way possible.

I grant LCHC permission to provide my dental treatment as discussed. I also understand that this treatment may not be covered by my insurance (if applicable) and any estimates of insurance coverage discussed by any staff member were provided to me as a courtesy. It is my responsibility to contact my dental insurance company (including any insurance provided by the state) to discuss and understand my policy.

I agree to inform Lakeshore Community Health Care of any changes in my medical history. This authorization expires in one year from date below, unless revoked verbally or in writing.

_____ _____

Signature (Parent/Guardian/Legal Representative) **Date**

OFFICE USE ONLY: ☐ Anterior ☐ Posterior LCHC Staff Initials: _____

LAKESHORE community health care

Household Income Assessment

MRN: _____
Office Use Only

REQUIRED FOR ALL PATIENTS

Full Name:_____ **Date:**_____ **Number of Family Members in Household:**____

Household Income $_____ ☐ **Bi-weekly** ☐ **Monthly** ☐ **Yearly** **OR CHECK ONE BELOW:**

Under $14,500	☐ $25,000 - $29,999	☐ $40,000 - $44,999	☐ $55,000 - $59,999	☐ $70,000 - $74,999
$14,501 - $19,999	☐ $30,000 - $34,999	☐ $45,000 - $49,999	☐ $60,000 - $64,999	☐ More than $75,000
$20,000 - $24,999	☐ $35,000 - $39,999	☐ $50,000 - $54,999	☐ $65,000 - $69,999	☐ Choose not to disclose

We encourage patients to apply for discounted care, even if you have insurance. LCHC is required to report anonymous patient income to the US Health Resources and Services Administration to receive grant funding that supports the discounted care program.

TO DECLINE DISCOUNTED CARE SIGN BELOW

I do not want to apply for discounted care at this time.

Signature:_____ Date:_____

TO APPLY FOR DISCOUNTED CARE ***Provide documentation within 30 days to see if you qualify for discounted care.***

Please attach copies of your most recent IRS 1040 form, social security income awards letter, last 30 days of paystubs and/or proof of any earnings as listed below. Failure to give complete records will result in the sliding discount fee not being applied to services. The patient will be responsible for all charges.

EARNINGS MAY INCLUDE: Taxable income earned, taxable net self-employment income, social security income, social security disability insurance/benefits (SSDI), alimony/spousal maintenance, unemployment compensation, taxable income (pension, retirement, annuities, interest, estate/trusts, etc.).

List ALL dependents (INCLUDING YOU) that you would claim on your tax return, their ages and earnings.

NAME	DATE OF BIRTH	SOURCE OF INCOME	GROSS EARNINGS	BI-WEEKLY, MONTHLY OR YEARLY

I agree that the above information is correct and all sources of earnings have been reported. I will report any earnings changes and will re-apply every twelve months even if no changes occur. Failure to meet these conditions may disqualify me from future discounted care at Lakeshore Community Health Care.

_____ _____

Signature (Parent/Guardian/Legal Representative) **Date**