

YOUR CHILD CAN RECEIVE **DENTAL CARE AT SCHOOL!**

The Morongo Basin Community Health Center is partnering with the Morongo Unified School District to offer preventative dental care at your school!



Your child can receive school-based dental care from the Morongo Basin Community Health Center. This local program is for students who are on Medi-Cal or who are Medi-Cal eligible who do not have a dental home, or would like the convenience of receiving dental care at school.

A new application	on is required	or each sch	ool year	Nan	ne of Child's	School:			
PLEASE COM	IPLETE								
Child's First Name:	Last Name:						Middle Inital:		
Date of Birth:	Age:	Grade:	Parent/Guardian Name:				Parent Birthdate:		
Mailing Address:			City:			S	tate:	Zip-code:	
Email:			Phone:				D V	Nork □ Home □ C∈	
			City:						
Gender Identity: Race : Primary Language?		an/Alaska Native o ☐More th	☐Asian nan One Rac	□Black/Africa e □Other: _	an American	□Native Hawaiia		☐ Pacific Islander pose Not to Disclose	
Are you Homeless?	□Yes □N		On the Stree	ss Shelter Other: signated for slee			ubled Up wit	n Friends	
IF YOUR CHIL		<u> </u>							
IMPORTANT: WE MUS		<u>IUMBER</u> IN ORD	ER FOR MO	RONGO BASIN	COMMUNITY	HEALTHCARE CE	NTER STAFF	TO SEE YOUR CHILI	
Enter Child's ID Number HERE	<u> </u>	ш						Medi-Cal covers 100%	
♦ Family monthly income \$ Number of dependents in household □ Declined to state □ I do not have insurance at this time. □ I would like Morongo Basin Community Health Center to contact me about Medi-Cal enrollment for my child.									
For emergency, w	hom mav we co	ontact about th	ne patient's	dental care?					
	ne: Relationship to Patient:								
	e number: Email:								
READ & SIGN	BELOW If you	have any que	stions or w	ould like to s	peak to par	t of the Dental Te	eam, call us	s at 760.362.8452	
I request that the Denta	al Team perform de	ental services or	mv child at	school which ma	av include: co	omplete dental exar	n. X-ravs and	d photos of teeth: teet	

cleaning, fluoride treatment, dental sealants; Interim Therapeutic Restoration; simple fillings and extractions; use of local or topical anesthetic. This consent for treatment includes future visits. I will report any significant changes in my child's health to 760.362.8452.

I certify that all information provided in this form is correct and true to the best of my knowledge. I understand that providing incomplete information could be dangerous to my child's health.

I have read the NOTICE OF PRIVACY PRACTICES and CONSENTS ON THE BACK OF THIS FORM, understand, and agree to its terms.

SIGN & DATE	SIGNATURE		DATE	
		DDINTED NAME IS VOLID DIGITAL SIGNATURE		

MEDICAL INFORMATION								
Name of primary physician:	Phone							
Is this child being treated by a physician at this time? □No □Yes If yes, please explain why.								
Is this child taking any prescription or over-the-counter medications or vitamin supplements at this time? □No □Yes								
If yes, please list them here.								
	F 1 FF 0 -N -V 16 1							
Has this child ever been hospitalized, had surgery, serious injury or medical condition? ☐No ☐Yes If yes, please explain.								
Is this child up to date on immunizations against childhood disea	ases?							
THIS CHILD HAS THE FOLLOWING K	NOWN ALLERGIES							
	☐ Latex (rubber) ☐ Sedatives							
☐ No known allergies☐ Codeine / narcotics☐ Foods	☐ Metals ☐ Sedatives ☐ Sulfa drugs							
☐ Local dental anesthetic ☐ Hay Fever / seasonal								
□ Animals □ lodine	☐ Penicillin / Antibiotics							
THIS CHILD HAS A HISTORY / COND	DITION RELATED TO THE FOLLOWING							
	ll that apply							
☐ None apply ☐ Chickenpox	☐ Hearing impairment ☐ Muscular dystrophy							
☐ Acid Reflux (GERD) ☐ Cystic fibrosis	☐ Heart condition ☐ Pregnancy (teen)							
☐ ADHD ☐ Diabetes 1 or 2 ☐ Down syndrome	☐ Hepatitis A/B/C☐ Rheumatic fever☐ Herpes / fever blisters☐ Seizures							
☐ Anemia☐ Down syndrome☐ Arthritis☐ Ear aches (chronic)	☐ Herpes / fever blisters☐ Seizures☐ Sickle cell anemia							
☐ Asthma ☐ Eating disorder	☐ Kidney disease ☐ Sinusitis							
☐ Autism ☐ Emotional impairment	☐ Liver condition ☐ Skin condition							
☐ Bladder disease ☐ Epilepsy	☐ Measles ☐ Speech impairment							
☐ Blood disorder ☐ Excessive bleeding	☐ Mental impairment ☐ Stomach condition							
□ Blood transfusion□ Fainting□ Growth problems	☐ Mononucleosis☐ Thyroid condition☐ Mouth breathing☐ Tobacco use / vaping							
☐ Cancer ☐ Hand / Foot / Mouth	☐ Mumps ☐ Tuberculosis							
☐ Cerebral palsy ☐ Headaches	☐ Venereal disease (STD)							
DENTAL HISTORY								
DENTAL HISTORY								
☐ Yes ☐ No Is this the child's first visit to a dental provider? ☐ Yes ☐ No Has the child had any problem with dental treatments	in the post? Date of first dental exam:							
Yes No Has the child had any problem with dental treatments of Yes No Has the child ever had dental radiographs (X-rays) exp	•							
Yes No Has the child ever suffered an injury to the mouth, hea	ad or tooth?							
☐Yes ☐No Does the child have jaw-joint problems (popping sound	AGE MHEH CHIID SIDDEG DIEGSLIEEUHD							
□Yes □No Does the child frequently clench or grind their teeth? Age when child stopped bottle feeding								
□Yes □No Has the child had any problem with the eruption or shedding of teeth?								
☐Yes ☐No Has the child had any orthodontic treatment? Please email completed form to:								
Yes No Does the child participate in active recreational activities	monligaental@mnnaistrict.org							
☐ Yes ☐ No Has a family member had cavities within the last 12 m ☐ Yes ☐ No Has the child had cavities or fillings within the last 3 yes	Diagon and 700 202 0452th							
Yes No Does the child suck their thumb, fingers or pacifier?	questions about this form. Leave a							
☐Yes ☐No Does the child snack on surgary food /drinks more tha	detailed message, including your name							
☐Yes ☐No Does the child brush with fluoride toothpaste? ☐1x/day ☐2x/day and call-back number. A member								
☐Yes ☐No Does the child rinse with fluoride mouth rinse once a day? our dental team w								
☐Yes ☐No Does the child brush with prescription fluoride toothpaste (5,000 ppm)? soon as possible.								
Yes No Does the child take fluoride supplements?	=)/amish =Tarisal							
☐Yes ☐No In the last 6 months has the child received fluoride?	□Varnish □Topical							

CONSENT FOR TREATMENT (REV 1/18)

- Consent for Treatment: Having chosen to be treated by the Morongo Basin Community Health Care (MBCHC) for out-patient services, I hereby
 consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the
 judgement of the attending provider.
- 2. **Prescription History:** I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by MBCHC providers and staff and it may include prescriptions back in time several years.
- 3. **Photography Consent:** I consent to the taking of photographs, video tapes, digital or other images of my medical or surgical condition or treatment, and the use of the images for the purpose of my diagnosis or treatment or for MBCHC's operations, including peer review, education, or training programs conducted by the center.
- 4. **Authorization to Release Information:** I hereby authorize MBCHC and all of my attending providers to release information and/or to facilitate the coordination of my health care with appropriate service providers.
- 5. **Authorization to Release Insurance Information:** I hereby authorize MBCHC and all of my attending providers to release information to complete insurance claim forms.
- 6. Assignment of Insurance Benefits: I hereby instruct and authorize my insurance carrier to make payments directly to MBCHC.
- 7. I understand that I am financially responsible for all charges.
- 8. I have received a copy of the MBCHC's Notice of Privacy Practices.

CONSENT FOR TELE DENTISTRY

What is a Tele-Dentistry Consultation? Tele-dentistry is a tool used to help people who do not or cannot go to a dentist's office to receive the benefit of routine dental examinations or consultations. Tele-dentistry uses electronic dental records like electronic versions of X-rays, photographs, recordings or the condition of your teeth, health and other health information. These records are reviewed by a dentist at a later time. The goal of the tele-dentistry system is to have the dentist create a treatment plan and recommendations for your dental care.

<u>What are the risks, benefits, and alternatives?</u> The benefits of tele-dentistry include having access to a dentist and additional dental information without having to travel to a dental office or clinic. A potential risk of tele-dentistry is that a face-to-face consultation with a dentist may still be necessary after the tele-dentistry appointment. At any time during the consultation, you can choose to get dental care in a dental office or dental clinic.

Confidentiality. Current federal and California laws about confidentiality apply to the information used or disclosed during your tele-dentistry consultation.

Rights. You may choose not to participate in a tele-dentistry consultation at any time before and/or during the consultation. If you decide not to participate it will not affect your right to future care or treatment. You have the option to seek dental consultation or treatment in a dental office at any time, before or after the tele-dentistry consultation. If any injury occurs as a result of the procedures provided by the dental hygienist, notify that person. They will make arrangements for appropriate treatment for the injury.

CHECK OUT THESE RESOURCES AVAILABLE TO YOU!







AFTER HOURS HOTLINE 760.365.9305

The Morongo Basin Community Health Center offers a Nurse Advice Line, open from 5pm to 8:30am. All calls will be answered live by nurses who can offer the caller advice on dental and medical services. The following business day, a staff member will call to follow up to schedule appointment or address any further questions.

AFFORDABLE HEALTHCARE 760.365.9305

WE PROVIDE PRIMARY AND SPECIALITY CARE. We accept most PPO insurances, Medi-Cal, IEHP, Medicare, and Tricare. Ask if you qualify for our discount-fee program. Evening and some Saturday appointments may be available. Services include adult and pediatric medicine, dental care, chiropractic, and behavioral health care for adults and children.

AFFORDABLE DENTAL CARE 760.820.4131

WE PROVIDE AFFORDABLE DENTAL CARE FOR ADULTS AND CHILDREN. Medi-Cal / IEHP and cash are accepted.

LIFT TRANSPORTATION SERVICES 760.366.5438

Call us to schedule **FREE** transportation services to your next medical or dental appointment. Our van is wheelchair friendly and our drivers will pick you up and return you to your home. Medical appointment transport is **NOT** limited to only the Morongo Basin Community Health Center Clinics.