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!

MORONGO BASIN COMMUNITY HEALTH CENTER
A SERVICE OF MORONGO BASIN HEALTHCARE DISTRICT

HEALTHY TEETH. HAPPY MOUTH.

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 is required for each school year

Name of Child's School: _____

PLEASE COMPLETE

Child's First Name: _____ Last Name: _____ Middle Inital: _____

Date of Birth: _____ Age: _____ Grade: _____ Parent/Guardian Name: _____ Parent Birthdate:_____

Mailing Address:_____ City: _____ State: _____ Zip-code: _____

Email: _____ Phone: _____ ☐ Work ☐ Home ☐ Cell

Pharmacy: _____ City: _____ Phone: _____

Gender Identity: ❒Male ❒Female ❒Other: _____

Race : ❒American Indian/Alaska Native ❒Asian ❒Black/African American ❒Native Hawaiian ❒White ❒ Pacific Islander
❒Hispanic/Latino ❒More than One Race ❒Other: _____ ❒Choose Not to Disclose

Primary Language? ❒English ❒Spanish ❒Other: _____

Are you Homeless? ❒Yes ❒No **If YES:** ❒In a Homeless Shelter ❒In Transitional Housing ❒Doubled Up with Friends
❒On the Street ❒ Other: _____
❒Space not designated for sleeping ❒Unknown

IF YOUR CHILD HAS MEDI CAL (also known as Benefits Identification Card, Denti Cal, I.E.H.P.)

IMPORTANT: WE MUST HAVE YOUR ID NUMBER IN ORDER FOR MORONGO BASIN COMMUNITY HEALTHCARE CENTER STAFF TO SEE YOUR CHILD.

Enter Child's ID Number HERE: | | | | | | | | | | | | | | |

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, whom may we contact about the patient's dental care?

Name: _____ Relationship to Patient: _____

Phone number: _____ Email: _____

READ & SIGN BELOW If you have any questions or would like to speak to part of the Dental Team, call us at 760.362.8452

I request that the Dental Team perform dental services on my child at school which may include: complete dental exam, X-rays and photos of teeth; teeth 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** _____

PRINTED NAME IS YOUR 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.

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 diseases? ❒Yes ❒No

THIS CHILD HAS THE FOLLOWING KNOWN ALLERGIES

- ❒ No known allergies
- ❒ Aspirin
- ❒ Local dental anesthetic
- ❒ Animals
- ❒ Codeine / narcotics
- ❒ Foods
- ❒ Hay Fever / seasonal
- ❒ Iodine
- ❒ Latex (rubber)
- ❒ Metals
- ❒ Pain medication
- ❒ Penicillin / Antibiotics
- ❒ Sedatives
- ❒ Sulfa drugs
- ❒ Other:

THIS CHILD HAS A HISTORY / CONDITION RELATED TO THE FOLLOWING

Check all that apply

- ❒ None apply
- ❒ Acid Reflux (GERD)
- ❒ ADHD
- ❒ Anemia
- ❒ Arthritis
- ❒ Asthma
- ❒ Autism
- ❒ Bladder disease
- ❒ Blood disorder
- ❒ Blood transfusion
- ❒ Bone disease
- ❒ Cancer
- ❒ Cerebral palsy
- ❒ Chickenpox
- ❒ Cystic fibrosis
- ❒ Diabetes 1 or 2
- ❒ Down syndrome
- ❒ Ear aches (chronic)
- ❒ Eating disorder
- ❒ Emotional impairment
- ❒ Epilepsy
- ❒ Excessive bleeding
- ❒ Fainting
- ❒ Growth problems
- ❒ Hand / Foot / Mouth
- ❒ Headaches
- ❒ Hearing impairment
- ❒ Heart condition
- ❒ Hepatitis A/B/C
- ❒ Herpes / fever blisters
- ❒ HIV+ / AIDS
- ❒ Kidney disease
- ❒ Liver condition
- ❒ Measles
- ❒ Mental impairment
- ❒ Mononucleosis
- ❒ Mouth breathing
- ❒ Mumps
- ❒ Muscular dystrophy
- ❒ Pregnancy (teen)
- ❒ Rheumatic fever
- ❒ Seizures
- ❒ Sickle cell anemia
- ❒ Sinusitis
- ❒ Skin condition
- ❒ Speech impairment
- ❒ Stomach condition
- ❒ Thyroid condition
- ❒ Tobacco use / vaping
- ❒ Tuberculosis
- ❒ Venereal disease (STD)

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 past?**
❒Yes ❒No **Has the child ever had dental radiographs (X-rays) exposed?**
❒Yes ❒No **Has the child ever suffered an injury to the mouth, head or teeth?**
❒Yes ❒No **Does the child have jaw-joint problems (popping sounds)?**
❒Yes ❒No **Does the child frequently clench or grind their teeth?**
❒Yes ❒No **Has the child had any problem with the eruption or shedding of teeth?**
❒Yes ❒No **Has the child had any orthodontic treatment?**
❒Yes ❒No **Does the child participate in active recreational activities?**
❒Yes ❒No **Has a family member had cavities within the last 12 months?**
❒Yes ❒No **Has the child had cavities or fillings within the last 3 years?**
❒Yes ❒No **Does the child suck their thumb, fingers or pacifier?**
❒Yes ❒No **Does the child snack on surgary food /drinks more than 3 times/day**
❒Yes ❒No **Does the child brush with fluoride toothpaste?** ❒1x/day ❒2x/day
❒Yes ❒No **Does the child rinse with fluoride mouth rinse once a day?**
❒Yes ❒No **Does the child brush with prescription fluoride toothpaste (5,000 ppm)?**
❒Yes ❒No **Does the child take fluoride supplements?**
❒Yes ❒No **In the last 6 months has the child received fluoride?** ❒Varnish ❒Topical

Date of first dental exam: _____

Date of last dental X-ray: _____

Age when child stopped breast feeding _____

Age when child stopped bottle feeding _____

Please email completed form to:
mobiledental@mbhdistrict.org
Please call 760-362-8452 with questions about this form. Leave a detailed message, including your name and call-back number. A member of our dental team will contact you as soon as possible.

CONSENT FOR TREATMENT (REV 1/18)

1. **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.

What are the risks, benefits, and alternatives? 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.

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