



## **Thank you for your interest in the Charles Drew Tooth Mobile Program!**

### **HOW DO I SIGN MY CHILD UP FOR THE TOOTH MOBILE?**

Each child needs to have a registration packet and consent form completed by their guardian in order to be seen on the Tooth Mobile.

### **WHAT SERVICES ARE PROVIDED ON THE TOOTH MOBILE?**

On the Tooth Mobile, each child will receive a cleaning, exam, x-rays, and fluoride varnish. If any urgent or emergent needs are discovered, additional treatments to include tooth extractions may be completed. Dental services such as silver crowns and fillings may need to be completed at a Charles Drew Health Center site. After every visit, the child will receive a postcard that should be taken home that explains what services were provided at the visit and if there are any follow-up instructions that the guardian should be aware of.

### **ARE SERVICES PROVIDED ON THE TOOTH MOBILE FREE?**

While the services are not free, Charles Drew Health Center accepts Medicaid and many insurance plans. In the event your child does not have insurance, Charles Drew Health Center has established a team of certified application counselors to aid in enrolling your child with dental insurance and would be happy to explore those options. If our team of eligibility and enrollment specialists finds that your child is ineligible for dental insurance or does not qualify for Medicaid benefits, Charles Drew Health Center offers a Sliding Fee Discount Program to help with out of pocket costs.

### **WHY SHOULD I PROVIDE MY INSURANCE INFORMATION?**

If a child is covered by insurance, Charles Drew Health Center must first seek reimbursement for costs from the insurance carrier.

### **WILL/CAN MY CHILD ALWAYS BE SEEN ON THE TOOTH MOBILE?**

The Tooth Mobile is intended to reach the community as an outreach opportunity and on a periodic basis. Charles Drew Health Center would be proud to serve as your child's primary dental provider and he/she can be seen at any of our dental locations. Please call 402.451.3553 to schedule an appointment.

### **IF MY CHILD WAS SEEN ON THE TOOTH MOBILE, WHY WERE THEY REFERRED TO ANOTHER CHARLES DREW HEALTH CENTER LOCATION?**

An attempt will be made to complete all necessary dental treatment on the Tooth Mobile. However, the child's comfort level may not warrant completion of treatment on the Tooth Mobile or the dental needs may be such that the child would benefit from treatment in a traditional dental setting. In these instances, a member of our staff will reach out to schedule an appointment for the child at a Charles Drew Health Center location.



# TOOTH MOBILE CONSENT FORM

The Tooth Mobile is a program of Charles Drew Health Center, Inc. designed to help children receive needed dental preventative and treatment on-site, while at school. If you already have a dentist, we encourage you to see them regularly for routine care.

## PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number (SSN): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
School: \_\_\_\_\_

Do you want your child to participate in this program?

**NO** Stop completing this form; no further information is needed.      **YES** Continue completing this form and the following sections.

## CONSENT TO RECEIVE DENTAL SERVICES & RELEASE OF LIABILITY

Please initial each line:

\_\_\_\_\_ I want my child to receive a **DENTAL EXAM** and **NECESSARY DENTAL TREATMENT**. I hereby authorize Charles Drew Health Center, Inc. to examine and treat my minor child or ward, and to perform procedures, including but not limited to: **cleaning, fluoride varnish, sealants, x-rays, fillings, silver crowns, and extractions (some may require local anesthesia)**, as necessary by the dentist. I authorize payment of dental insurances to include Medicaid benefits directly to Charles Drew Health Center, Inc. I authorize Charles Drew Health Center, Inc. to share my dental record and to share the record with any specialty care provider that may be needed in the course of my care.

\_\_\_\_\_ **NOTICE OF PRIVACY PRACTICES** I understand the Notice of Privacy Practices of Charles Drew Health Center, Inc. is available at my child's school. I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I have the right to revoke this consent at any time by giving written notice and that my revocation could result in the discontinuance of treatment by Charles Drew Health Center, Inc. I further understand that Charles Drew Health Center, Inc. reserves the right to change the Notice of Privacy Practices as they have been described. If the Notice of Privacy Practices is revised, the new Notice of Privacy Practices will be issued to the school and available to me. Those changes may also apply to any of the protected health information.

\_\_\_\_\_ **EMERGENCIES** If a medical emergency should occur, the mobile unit may call the school and 911 and emergency fees may be assessed to the patient.

\_\_\_\_\_ **MEDIA RELEASE** I understand that my child may be photographed directly or indirectly while participating with this program. I understand that the purpose of such media is for advertisement and promotion of the mobile dental clinic program. I give permission by initialing for the photos to be reproduced and printed for such purposes.

\_\_\_\_\_ **TREATMENT AT CHARLES DREW HEALTH CENTER, INC.** I understand that if I choose to bring my child to Charles Drew Health Center, Inc., there may be a fee for services provided. Charles Drew Health Center, Inc. dental clinic accepts Medicaid and many insurance plans. In the event that my child does not have insurance or qualify for Medicaid benefits, I understand the Charles Drew Health Center, Inc. offers a sliding fee scale program, based on family size and household income.

*Available and appropriate care and treatment services offered to patients solely on the basis of condition without differentiation or consideration of: race, age, sex, disability, national origin, religion, sexual orientation, gender identity, immigration status, or ability to pay.*

Parent or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Relationship to Child: \_\_\_\_\_

## PATIENT REGISTRATION FORM

*All information requested within this form is essential to ensure quality patient care or required by federal law. It will be kept private and confidential as a part of the patient's medical record.*

### SECTION I: PATIENT INFORMATION AND DEMOGRAPHICS

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Social Security Number (SSN): \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Preferred Language: \_\_\_\_\_ Interpreter Needed?: Yes No

Please check which of the following best describes your race. Please only select one:

- |                                   |                       |                           |  |
|-----------------------------------|-----------------------|---------------------------|--|
| American Indian or Native Alaskan | Asian Indian          | Black or African American | Chinese                                  |
| Filipino                          | Guamanian or Chamorro | Japanese                  | Korean                                   |
| Native Hawaiian                   | Samoaan               | Vietnamese                | Other Asian                              |
| Other Pacific Islander            | White                 | More than one race        | Unknown, not listed, or refuse to report |

Please check which of the following best describes your ethnicity. Please only select one:

- |              |   |                |  |
|--------------|---|----------------|--|
| Chicano      | Cuban                                     | Mexican        | Mexican American                           |
| Puerto Rican | Not Hispanic, Latino/a, or Spanish origin | Other Hispanic | Unreported/Chose not to disclose ethnicity |

Please check which of the following best describes your primary medical coverage type. Please select only one:

- |          |          |   |                   |
|----------|----------|---|-------------------|
| Medicaid | Medicare | Private or commercial insurance (including through Marketplace) | None or uninsured |
|----------|----------|---|-------------------|

### SECTION II: PATIENT HOUSEHOLD INFORMATION

Please **MARK** your family size and household income range (first find family size then find income range in same row)

Family Size	Annual Income Ranges					
1	\$0-\$15,650	\$15,650.01-\$19,562.49	\$19,562.50-\$23,474.99	\$23,475-\$27,387.49	\$27,387.50-\$31,300	Over \$31,301
2	\$0-\$21,150	\$21,150.01-\$26,437.49	\$26,437.50-\$31,724.99	\$31,725-\$37,012.49	\$37,012.50-\$42,300	Over \$42,301
3	\$0-\$26,650	\$26,650.01-\$33,312.49	\$33,312.50-\$39,974.99	\$39,975-\$46,637.49	\$46,637.50-\$53,300	Over \$53,301
4	\$0-\$32,150	\$32,150.01-\$40,187.49	\$40,187.50-\$48,224.99	\$48,225-\$56,262.49	\$56,262.50-\$64,300	Over \$64,301
5	\$0-\$37,650	\$37,650.01-\$47,062.49	\$47,062.50-\$56,474.99	\$56,475-\$65,887.49	\$65,887.50-\$75,300	Over \$75,301
6	\$0-\$43,150	\$43,150.01-\$53,937.49	\$53,937.50-\$64,724.99	\$64,725-\$75,512.49	\$75,512.50-\$86,300	Over \$86,301
7	\$0-\$48,650	\$48,650.01-\$60,812.49	\$60,812.50-\$72,974.99	\$72,975-\$85,137.49	\$85,137.50-\$97,300	Over \$97,301
8	\$0-\$54,150	\$54,150.01-\$67,687.49	\$67,687.50-\$81,224.99	\$81,225-\$94,762.49	\$94,762.50-\$108,300	Over \$108,301

### SECTION III: INSURANCE INFORMATION

Insurance Name: \_\_\_\_\_ Policy number/Enrollment ID: \_\_\_\_\_

Group ID: \_\_\_\_\_ Member ID: \_\_\_\_\_

### SECTION IV: EMERGENCY CONTACT INFORMATION

Emergency Contact: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

How did you hear about Charles Drew Health Center, Inc.? \_\_\_\_\_

### SECTION V: FINANCIAL RESPONSIBLE PARTY INFORMATION

*Should match insurance card, if applicable. Only complete this section if the responsible party is different from patient.*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Social Security Number (SSN): \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please fill out any/all contact methods. Check box for preferred contact method:

Cell Phone: \_\_\_\_\_ May we leave a voicemail? Yes No

Alt. Phone: \_\_\_\_\_ May we leave a voicemail? Yes No

Email Address: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Interpreter Needed?: Yes No

*I authorize release of information regarding continuation of care and/or any payments for services. I authorize a copy of this document may be used as the original document. I certify all information provided is true and accurate to the best of my knowledge.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



Charles Drew

HEALTH CENTER, INC.

"Growing a Healthy Community"

## DENTAL HEALTH HISTORY

### PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security Number (SSN): \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer each question **for the patient** and provide additional information when required:

Are you in good health?	Yes	No	<b>FOR WOMEN PATIENTS ONLY:</b>		
Have there been any recent changes in your health?	Yes	No	Are you pregnant or is there any chance you could be?	Yes	No
Date of last physical exam: ____/____/____			Are you nursing?	Yes	No
Are you under a physician's care for any problems?	Yes	No	Are you taking oral contraceptives?	Yes	No
Have you ever had any serious illnesses, operations, or hospitalizations?	Yes	No			

### Is the patient taking any of the following

Antibiotics?	Yes	No	Insulin or diabetic drugs?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Fosamax or biophosphonate?	Yes	No
Antidepressants?	Yes	No	Are you taking other drugs or medications? If <b>yes</b> , which drugs/medication and how much:	Yes	No
Cortisone (steroids)?	Yes	No			
Medicine for high blood pressure?	Yes	No			
Aspirin?	Yes	No			

### Is the patient allergic or has the patient adversely reacted to any of the following:

Latex?	Yes	No	Metals?	Yes	No
Local anesthetic?	Yes	No	Pain medication?	Yes	No
Penicillin?	Yes	No	Other:		

### Please indicate any history of the following:

Heart surgery or artificial heart valve?	Yes	No	Radiation treatment to head or neck region?	Yes	No
Congenital heart defect?	Yes	No	Any bleeding conditions or disorders?	Yes	No
ADD/ADHD?	Yes	No	Fainting spells or seizures?	Yes	No
Heart attack?	Yes	No	Osteoporosis?	Yes	No
Stroke?	Yes	No	Hepatitis or jaundice?	Yes	No
High/low blood pressure	Yes	No	Kidney problems?	Yes	No
Asthma?	Yes	No	Arthritis?	Yes	No
Persistent or bloody cough?	Yes	No	Mental health issues?	Yes	No
Tobacco Use?	Yes	No	Do you have any other medical conditions?	Yes	No
Cancer?	Yes	No	If yes, please explain:		
Artificial joint (hip, knee) implants, prosthesis?	Yes	No			

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. If there are any changes in my health, or medicines, I will inform my dentist at my next appointment.

Patient or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Interpreter's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



# FINANCIAL ASSISTANCE APPLICATION

## SECTION I: PATIENT/GUARANTOR INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## SECTION II: HOUSEHOLD INCOME

Charles Drew Health Center, Inc. defines family size as the total number of members in the patient or guarantor's household. Household members may include self, spouse, dependents, or anyone within the residence for which the head of household provides monetary support.

patient or household. Examples of proof of income sources include: most recent tax returns, most recent paycheck stub(s), or statement of income determination for federal, state, or local government.

Charles Drew Health Center, Inc. defines income as earnings over a period of time, usually annually, used to support the

Note: The below table does not determine eligibility, but allows Charles Drew Health Center, Inc. to assess your qualification for other financial assistance.

Family Household Member (Name)	Age	Relationship to Applicant	Income			
			Amount	Period	Office Use Only: Annualized Income	
		Self	\$	Weekly Monthly Other:	Bi-weekly Annually	
			\$	Weekly Monthly Other:	Bi-weekly Annually	
			\$	Weekly Monthly Other:	Bi-weekly Annually	
			\$	Weekly Monthly Other:	Bi-weekly Annually	
			\$	Weekly Monthly Other:	Bi-weekly Annually	

Total Household Size: \_\_\_\_\_ Total Annual Household Income: \_\_\_\_\_

I certify the information given on this form and the provided income documentation is complete, true, and correct to the best of my knowledge. If I do not qualify for financial assistance, I agree to pay the outstanding balance in full. I agree and understand that financial assistance may not apply to all of the services provided at Charles Drew Health Center, Inc. If account balances are not paid, I agree to pay the resulting collection charges, legal fees, and understand access to CDHC services may be terminated. I understand I will be required to reapply by submitting a new Financial Assistance Application if my income changes prior to the expiration date below or if my income changes.

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I choose not to disclose income or opt-out and therefore choose not to participate in the Sliding Fee Discount Program. I understand that I will be charged full fee for all services and will not be eligible for any discounts.

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient MRN: \_\_\_\_\_

**OFFICE USE ONLY** Proof of Income Received: Yes No Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient qualifies for following discount: L0 L1 L2 L3 L4 L5

Staff Representative: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



# SELF-ATTESTATION WORKSHEET

## Patient/Guarantor Information

Patient/Guarantor First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Charles Drew Health Center, Inc. requires patients or guarantors to provide documentation of income to be eligible to participate in the Sliding Fee Discount Program. Charles Drew Health Center, Inc. defines income as earnings over a period of time, usually annually, used to support the patient or household.

### Please answer the following questions and provide additional information when required:

<p>Do you receive income?</p>	<p>No If no, you are attesting that you have \$0 income. Please sign below.</p>	<p>Yes \$ _____ Weekly      Bi-weekly Monthly     Annually Other</p>	<p><b>Office Use Only: Annualized</b></p>
<p>Can you provide documentation of your income? (E.g. pay stub, tax return, self-employment ledger, etc.)</p>	<p>No If no, what is your source of income?</p>	<p>Yes If yes, please provide documentation <b>within 30 days.</b></p>	

I certify the information given on this form is complete, true, and correct to the best of my knowledge. If found to be untruthful, I understand access to CDHC services may be terminated. I understand I will be required to reapply by submitting a new Financial Assistance Application if my income changes.

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

<p><b>Office Use Only:</b></p>	<p><b>Patient MR #:</b> _____</p>
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