Welcome to HealthSource Mobile Dental

- Complete and sign the required documents and return to your child's school.
- Scheduling may be delayed if there are missing documents or information is illegible.

For your convenience, you can complete these documents directly on your computer. You may electronically sign the form, or print and sign the forms.

- Send printed forms with your student to school
- Print and Fax the forms to **513-214-2408 Attn: Stephanie**

Please note that documents you send electronically may not be protected until they are received by HealthSource and saved in our system. We recognize these forms ask for private information about you and your child. Please make the choice that is best for you family.

Patient Information & Consent for Services			
Today's Date:	Patient's Last Name:	Patient's First Name:	Patient's DOB:
Patient's School:		Teacher & Home Room:	Grade:
Patient's Address:		Patient Phone #:	Student ID #:

Dental Services

☐ **YES,** I consent for my child to receive **dental** services at the HealthSource mobile dental team, which could include preventative care, dental examinations, x-rays, sealants, and fluoride.

☐ **NO,** I do not wish for my child to receive **dental** services.

Transportation Services

☐ **YES,** I consent for my child to be **transported/accompanied** to and from the SBHC by a school designee. I, the parent/guardian, of above-named student, release HealthSource and its Board Members, its employees, and authorized agents/representatives from all liability to personal injury or damage resulting from the transportation to or from the school for these purposes.

☐ **NO,** I do not wish for my child to be **transported/accompanied** to or from school for these purposes.

Answer the following questions so that we can contact you in the most efficient way possible:	YES	NO
May we send/receive clinical information from health care providers participating in your care?	☐	☐
If you have an answering machine at home, may we leave a message	☐	☐
May we leave a message at your work for you to call our office?	☐	☐
May we text appointment reminders?	☐	☐
Is there a person at your house we may leave a message with? If yes, please list their name:	☐	☐

List below a person/persons authorized by you to discuss/receive/access your medical information:

Last Name:	First Name:	Relation to Patient:
Last Name:	First Name:	Relation to Patient:

Patient Information

Today's Date:	Patient's Last Name:	Patient's First Name:	MI:	Nickname:	SSN:	Patient's DOB:

Birth Gender:	Current Gender:	Preferred Language:	Religion:	Marital Status:	Student Status:
☐ Female ☐ Male	☐ Female ☐ Male			☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated	☐ No ☐ Full-Time ☐ Yes ☐ Part-Time

Patient Billing Address (responsible party):

Patient Residence (if different):

Check all that apply:	Receive notifications by:	Check which contact number you prefer:	Parent/Guardian Email Address:
☐ Veteran ☐ Smoker ☐ Hearing Impaired ☐ Visually Impaired	☐ Opt Out ☐ Email ☐ Text ☐ Voicemail	☐ Cell Phone # _____ ☐ Home Phone # _____ ☐ Work Phone # _____	

Emergency Contact Name:	Emergency Contact Relationship:	Emergency Contact Phone #:

Statistics Required for Governmental Reporting:

Check all that apply:	Race:	Ethnicity:
☐ Homeless ☐ Migrant Farm Worker ☐ Language Barrier	☐ Black/African American ☐ White/Caucasian ☐ American Indian/Alaska Native ☐ Asian ☐ Hawaiian/Pacific Islander ☐ More than one	☐ Hispanic/Latino ☐ Decline ☐ Non-Hispanic/Latino ☐ Unknown

Financial Information – Responsible Party (required for patients less than 18 and when the guarantor is not the patient):

Last Name:	First Name:	MI:	SSN:	DOB:	Relationship:

Insurance Information (please present all insurance cards and a picture ID to the receptionist):

Medical Insurance:	Policy #:	Group #:	Effective:	Co-Pay:	Policy Holder:	Relationship:
Dental Insurance:	ID:	MMIS#:	Effective:	Co-Pay:	Subscriber:	Subscriber DOB:
Vision Insurance:	Policy #:	Group #:	Effective:	Co-Pay:	Policy Holder:	Relationship:

Insurance Information (please present all insurance cards and a picture ID to the receptionist):

It is the policy of HealthSource of Ohio to provide essential services to those who have no means or limited means to pay for their medical services (uninsured or underinsured). Discounts will be based on income and family size only. Please complete the following information to determine if you or members of your family are eligible for a discount.

***For the purposes of assistance, family is defined as: a group of two or more people, related by birth, marriage, or adoption and residing together, all such people, including related subfamily members, are considered members of one family.*

Section (a): Total combined income for all persons working in the household.
Section (b): How often do you get paid?
Section (c): Any additional income received in the household.
Section (d): Total number of people the household income supports.

All information will be kept confidential

(a) Total household income before taxes:	(b) How often do you get paid?	(c) Other Income:	(d) Total # of people supported by income:
	☐ Hourly: ☐ Weekly: ☐ Bi-Weekly: ☐ Monthly: ☐ Yearly:		

Consent to Dental Treatment

I consent for my child to receive dental service with the HealthSource mobile dental team, which could include preventative care, dental examinations, x-rays, sealants, and fluoride. I understand that:

a. The practice of medicine, dentistry, surgery, and behavioral health is not an exact science and acknowledge that treatment may involve risks such as life-threatening complications, including death, as well as benefits, and that there may be alternatives to recommended treatments. I acknowledge that no guarantees have been made to me about the results of examination and treatment by this office and HealthSource of Ohio.
b. Normally, except under emergency or extraordinary circumstances, no important procedures are performed on a patient unless and until he/she has had an opportunity to discuss them with the provider. Behavioral health patients will have an opportunity to discuss plans of care with the provider.
c. I should always ask my doctor or provider to explain any part of my care or treatment which I do not understand and have the right to have my questions answered to my satisfaction.
d. I have the right to agree or to refuse any recommended procedure or course of treatment.
e. I will not take part in any experimental procedure, treatment or research without complete knowledge and agreement.
f. HealthSource of Ohio is a Federally Qualified Health Center and offers a reduced fee to eligible patients and their families based on family size and income. The physicians, providers, and staff of HealthSource may be considered federal employees under the Federally Supported Health Centers Assistance Act of 1992 and 1995.
g. There may be medical, dental, nursing, behavioral health, and other healthcare personnel at this office who are still in training. I understand that they may be present and participate in my care.
h. I may refuse to sign this if I wish.

Consent for Release of Protected Health Information (PHI) for Treatment, Payment & Operations

I understand that HealthSource of Ohio (HSO) creates, receives, and maintains medical and healthcare information about me, or the patient above, as part of healthcare (PHI). Examples of this information include health history, test results, diagnoses, provider orders for treatment and referrals, and documentation of office visits. This information is used for several purposes, such as:

a. Planning my care & treatment and communicating among the healthcare providers who care for me.
b. Documenting services for billing any insurance or government benefit program (Medicare or Medicaid) for costs of my care and payment for those costs.
c. HSO operations. Including checking on the quality of my care, reviewing the way my providers care for me, and sending data required by federal and state healthcare agencies.

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have been given a copy of HSO's NOTICE OF PRIVACY PRACTICES, which has more information about how HSO uses and discloses my PHI and that I can review this Notice prior to signing this form. Since HSO can change this Notice, I can also request that HSO send me the latest copy of the Notice to review. I may refuse to sign this if I wish.

I consent to the use and disclosure of my PHI by HSO to affiliates, third parties, insurers, government healthcare programs, other healthcare providers and to other organizations to whom disclosure is permitted by the current HIPAA Privacy Rules at 45 CFR Parts 160 and 164f and as amended from time to time.

I give my permission for HSO to release my PHI to the following common organizations for services, payment for services, to meet government requirements or to assist in my referral for care by another provider. I understand that my health records may contain information about sexually transmitted disease testing and/or conditions, such as human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), substance abuse and behavioral/mental health treatment. I understand that this list does not cover every situation where my PHI may be used or disclosed:

a. Medicare or Medicaid offices and agents
b. My insurance company
c. Physicians, hospitals, home agencies, long-term care and other healthcare facilities and services selected by me
d. School health officials as part of school health programs
e. County/state health departments and public health agencies
f. Women, Infants & Children (WIC) program and Maternal/Child Health Program

I understand that I may revoke (take back) this Consent in writing, by delivering written notice to HealthSource of Ohio at 424 Wards Corner Rd. Suite 200 Loveland, OH 45140, Attn: Privacy Officer. You decision will become effective thirty (30) days after we receive you notice. Information used and disclosed by HSO before your revocation was received is not covered by the revocation.

I acknowledge the consent for treatment form above has been fully explained to me and I understand all the information as it applies to healthcare treatment by HealthSource of Ohio and the providers and staff of this office.

Acknowledgement and Financial Responsibility Statement

1. I understand that I am ultimately responsible for the payment of all healthcare services rendered by HealthSource of Ohio.
2. I hereby authorize assignment of insurance benefits, including Medicare or Medicaid, due and payable for health services rendered to me (or my dependent) be paid directly to HealthSource of Ohio.

Acknowledgement

By signing below, I acknowledge that I have reviewed and understand the information listed below as provided to me by HealthSource of Ohio.

1. Acknowledgement of Receipt of Notice of Privacy Practices
2. Consent to Medical/Dental/Behavioral Health Treatment
3. Consent for release of Protected Health Information (PHI) for Treatment Payment and Operations
4. Acknowledgement and Financial Responsibility Statement
5. Consent to School Based Health Center Services

Parent or Guardian Signature | Parent or Guardian Printed Name | Date

Patient Information			
Today's Date:	Patient's Last Name:	Patient's First Name:	Patient's DOB:
Patient's Primary Care Provider:	Preferred Pharmacy:		Pharmacy Phone #:

Medical History			
Date of last physical exam (Head-to-Toe):			Provider's Name:
	YES	NO	
Have they ever been pregnant?	☐	☐	# Of Pregnancies: # of Living Children:
Any previous head injuries?	☐	☐	
Any developmental delays?	☐	☐	
Any learning disabilities?	☐	☐	If yes, please list:
Any physical limitations?	☐	☐	If yes, please list:
Immunizations up to date?	☐	☐	
Are they currently taking any medications?	☐	☐	
Please list current medications (including vitamins, supplements, and other OTC medications):			
	YES	NO	
Are they allergic to any medications?	☐	☐	If yes, please list:
Are they allergic to penicillin/amoxicillin?	☐	☐	
What are the symptoms of the allergy?			

Dental History			
	YES	NO	
Have they ever been to the dentist?	☐	☐	
Date of last complete dental exam:			Provider's Name:
Are you aware of any particular problem?			
Do they brush their teeth? ☐ Only morning ☐ Only night ☐ Both morning and night ☐ Rarely ☐ Never			
Do they floss their teeth? ☐ Only morning ☐ Only night ☐ Both morning and night ☐ Rarely ☐ Never			
	YES	NO	
Do they have any dental pain?	☐	☐	Other dental concerns?
Have they ever had fluoride treatments?	☐	☐	
Have they learned the importance of primary teeth?	☐	☐	

Surgical History	YES	NO		YES	NO
Appendectomy	☐	☐	Hernia Repair	☐	☐
Adenoidectomy	☐	☐	Hysterectomy	☐	☐
C-Section	☐	☐	Lymph node	☐	☐
Ear Tubes	☐	☐	Tonsillectomy	☐	☐
Gall Bladder	☐	☐	Other:		

HealthSource of Ohio

HealthSource of Ohio
Patient Home, School, & Health History Form

Patient Information			
Today's Date:	Patient's Last Name:	Patient's First Name:	Patient's DOB:

Does the student or any family member have any of the following problems currently or in the past?

PROBLEM	STUDENT YES	FAMILY YES	PROBLEM	STUDENT YES	FAMILY YES	PROBLEM	STUDENT YES	FAMILY YES
Asthma/Wheezing	☐	☐	Eye Trauma	☐	☐	Seizure Disorder	☐	☐
Allergy/Hay Fever	☐	☐	Fainting w/Exercise	☐	☐	Sickle Cell	☐	☐
Allergy/Food	☐	☐	Glaucoma	☐	☐	Sinus Issues	☐	☐
Allergy/Pets	☐	☐	Headaches/Frequent	☐	☐	Sleep Apnea	☐	☐
ADHA/ADD	☐	☐	Hearing Loss/Concern	☐	☐	Sleep Issues	☐	☐
Anemia/Blood	☐	☐	Heart Disease	☐	☐	Snoring	☐	☐
Anaphylactic Reaction	☐	☐	Heart Murmur	☐	☐	Sore Throat/Frequent	☐	☐
Acne	☐	☐	Kidney Disease/Issues	☐	☐	Speech Issues	☐	☐
Alcohol Abuse	☐	☐	High Blood Pressure	☐	☐	Spinal Curvature	☐	☐
Behavior Issues	☐	☐	HIV/AIDS	☐	☐	Stomachache/Freq.	☐	☐
Bleeding Disorder	☐	☐	Hives	☐	☐	Stroke	☐	☐
Bowel Movements	☐	☐	Hyperactivity	☐	☐	Suicide Attempt(s)	☐	☐
Broken Bones	☐	☐	Joint Problems	☐	☐	Testicle Not in Sac	☐	☐
Cancer	☐	☐	Lazy Eye	☐	☐	Toothache/Dental	☐	☐
Cataract	☐	☐	Lead Poisoning	☐	☐	Tuberculosis	☐	☐
Chicken Pox	☐	☐	Learning Problems	☐	☐	Twitching Eyelid	☐	☐
Chronic Ear Infections	☐	☐	Leukemia	☐	☐	Underweight	☐	☐
Cholesterol High	☐	☐	Light Sensitivity	☐	☐	Urinary Tract Infections/Frequent	☐	☐
Concussion	☐	☐	Lumps Groin/Breast	☐	☐	Vaginal Discharge	☐	☐
Constipation	☐	☐	Mental Illness	☐	☐	Watery Eyes	☐	☐
Depression	☐	☐	Migraines	☐	☐	Anxiety	☐	☐
Diabetes	☐	☐	Muscle Problems	☐	☐	Drug Abuse	☐	☐
Diarrhea	☐	☐	Nervous Twitch/Tics	☐	☐	Pneumonia	☐	☐
Dizzy/Lightheaded	☐	☐	Nose Bleeds/Frequent	☐	☐	Prematurity	☐	☐
Dry/Burning Eyes	☐	☐	Nightmares	☐	☐	Epi-Pen Needed	☐	☐
Eczema/Skin Infection	☐	☐	Obesity	☐	☐	Sexually Transmitted Infections	☐	☐
Eye Strain	☐	☐	Rheumatic Fever	☐	☐	Thyroid Disorders	☐	☐

☐ By checking this box, I am acknowledging that I have reviewed the document and there is no student or family history of the problems listed above.

Parent/Guardian Signature or Patient/Student Signature (Only if 18 or older)	Parent/Guardian Print or Patient Student Print (Only if 18 or older)	Date