

Who: Give Kids A Smile Mobile Dental Clinic

Where: _____

When: _____

Please turn forms into the nurse or apply online by: ____/____/_____

Who is eligible: Any child ages 1-18 with Medicaid **OR** no dental insurance.

How often: Children can be seen every 6 months for preventative care.

Services: Dental exam, cleaning, fluoride.

Other services: If needed; sealants and/or silver diamine fluoride (SDF; treats cavities).

How to apply: Fill out pages 5 & 6 with your insurance information & give to the nurse.

OR Fill out online at epatientcenter.com using the password "Bethany" (capital B).

OR Scan the QR Code at the top right of this page. For multiple entries you may need to clear your cache/browser or use a different browser or device.





Dental forms are good for 12 months, please notify us of any health changes. If you have any questions OR changes in health history please contact your school nurse or the GKAS Dental Program Supervisor, Melody Mosenfelder: Phone: (309) 581-6211 or Email: mmosenfelder@bethany-qc.org

———TEAR OFF AND KEEP THIS PAGE FOR YOUR RECORDS———

BETHANY4CF

Bethany for Children & Families

www.bethany-qc.org

How to Help Prevent Cavities

Control the amount of plaque (germs) on your teeth!



- Brush your teeth daily.
  - Try to brush your teeth in the morning, afternoon and at night. If you can't do all three, definitely brush at night right before bed.
  - Brush for two minutes each time.
  - Be gentle!
- Floss your teeth daily!
  - Floss at least once a day.
  - "Hug" the tooth with the floss and move in an up and down motion.

Control the types of sugars you eat and drink!



- Sticky sugars (foods) can get stuck in the natural grooves and pits found on your teeth (mainly your back teeth) and can cause cavities if not brushed thoroughly after eating.
- Liquid sugars (drinks) can flow between your teeth when drinking, causing cavities to form between your teeth. If you must drink something sugary, use a straw and follow each drink with a sip of water.

Control the amount of time spent eating and drinking sugary items throughout the day!



- Eating well-balanced meals can help cut down the amount of snacking you do throughout the day.
- Save sugary foods for meal times. If you must snack between meals, choose foods with little or no added sugar.
- Drink sugary beverages only with meals. If you are thirsty between meals, drink water!

Tips for Healthy Teeth

Give Kids A Smile!

ADA American Dental Association®

Brush 2 times a day for **2 minutes** with a fluoride toothpaste

Clean **between** teeth

Avoid sugary foods including **soda** and **juices**

Eat a **healthy, well-balanced diet** with limited snacks

Visit your **dentist regularly**

Thanks to our GKAS day sponsor:

BRIGHT SMILES, BRIGHT FUTURES™ Colgate®

Good oral health is an important part of overall health. *For more healthy teeth tips, visit:* **MouthHealthy.org**

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GIVE KIDS A SMILE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Dentists participating in the Give Kids a Smile program may be required by applicable federal and state law to main the privacy of your health information. Protection of patient privacy is important to participants in the Give Kids a Smile program. This notice summarizes the privacy practices that will be followed by participants in the Give Kids a Smile program, and your rights concerning your health information. This Notice will apply to health information collected in connection with the Give Kids a Smile program and will remain in effect until replaced.

You may request a copy of the Notice of Privacy Practices at any time. For more information about the privacy practices, or for additional copies of this Notice, please contact Bethany for Children & Families at (309) 797-7700.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment. For example, we may use or disclose your health information to another dentist, physician, or other health care provider providing treatment to you.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person involved in your treatment to the extent necessary to help with your health care.

Persons Involved in Care: We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us at (309) 797-7700 for assistance in reaching the dentist or facility holding your health information.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last six years, but not before April 14, 2003.

Restriction: You may request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You may request that we communicate with you about your health information by alternative means or to alternative locations. We may agree to reasonable requests.

Amendment: You may request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS & COMPLAINS

If you want more information about our privacy practices or have questions or concerns, please contact us at (309) 797-7700. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your health information, or to have us communicate with you by alternative means or at alternative locations, you may contact us at (309) 797-7700. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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GIVE KIDS A SMILE

Silver Diamine Fluoride Consent Form (SDF)

Silver Diamine Fluoride (SDF) is an antibiotic liquid. We use SDF on cavities to help stop tooth decay from growing. We also use it to treat tooth sensitivity. Treatment with SDF does not eliminate the need for dental fillings or crowns to repair function or esthetics. While SDF can treat the bacteria that causes tooth decay, it will not restore the tooth structure that has been affected by the disease process. You may still require restoration of the teeth such as fillings, crowns or possible nerve treatment. Repeat applications of SDF have been shown to provide the best results; one application can stop decay by up to 70%. **If the dentist prescribes additional applications we will return to your student's school to apply additional applications.**

Benefits of receiving SDF: SDF can help stop tooth decay, SDF can help relieve sensitivity, SDF can postpone the need for traditional dental treatment, SDF can delay or eliminate the need for sedation/general anesthesia to complete dental treatment in young children and adults

Alternatives to SDF Include but are not limited to: No treatment, Placement of fluoride varnish, Restorative dental treatment such as fillings, crowns, nerve therapy

Most Common Risks related to SDF Treatment: The affected area will stain black permanently. Healthy tooth structure will not stain. Stained tooth structure can be replaced with a filling or a crown. Tooth-colored fillings and crowns may also discolor if SDF is applied to them. Normally this color change is temporary and can be polished off. If accidentally applied to the skin or gums, a brown stain may appear that causes no harm and will disappear in 1-3 weeks . You may notice a metallic taste, this will go away rapidly. If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such repeat SDF application, a filling or crown, root canal treatment, or extraction. These side effects may not include all of the possible situations reported by the manufacturer. If you notice other effects, please contact your dental provider.

Most Common Side Effects: With the application of Silver Diamine Fluoride (SDF) on top of a cavity will turn the cavity portion of the tooth dark. If SDF comes in contact with skin and/or gums, temporary discoloration will occur that may take up to 1-3 weeks to go away. If SDF is placed on a tooth that has a tooth colored restoration, discoloration may occur. **The front teeth will be avoided if possible.**

Authorization for Dental Treatment: I authorize The Give Kids a Smile Program with Bethany For Children & Families and their associates to provide and/or administer the dental service Silver Diamine Fluoride to my student, if their associates determine in their professional judgement, necessary or appropriate in my student's care. I understand that repeat applications of SDF have been shown to provide the best results. I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment. I understand that my student should not be treated with SDF if they are allergic to silver, or if they have painful sores or raw areas on my gums (i.e., ulcerative gingivitis) or anywhere in their mouth (i.e., stomatitis). I realize that it is mandatory that we follow any instructions given by the dentist and dental office staff. Alternative treatment options, including no treatment, have been provided. No guarantees have been made as to the results of treatment. I understand the most common risks/side effects associated with SDF that are stated above. ***Colored pictures can be seen on our website at https://www.bethany-qc.org/give-kids-a-smile***

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS PAGE and authorize Bethany for Children & Families to treat my student with Silver Diamine Fluoride if needed. Please sign on page 6.



Photos Courtesy of Elevate Oral Care

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GIVE KIDS A SMILE — PERMISSION FORM

PLEASE PRINT CLEARLY & RETURN TO SCHOOL

Bethany for Children & Families

give kids a smile! Children's Dental Access Program

Student's First Name	Student's Last Name	Date of Birth: Month/Day/Year	Gender
		/ /	☐ M ☐ F

Home Address	City	State	Zip Code

Parent/Guardian First Name	Last Name	Phone	Email Address

Emergency Contact Name (If other than Parent/Guardian)	Relationship to student	Emergency Contact Phone
		☐

Daycare/School Attending	Homeroom teacher	Grade Level

Please enter **Medicaid #** in boxes: ☐☐☐☐☐☐☐☐☐☐☐

PLEASE ENTER MEDICAID ID NUMBER IN BOXES ABOVE

What race do you consider your student? (needed for grant purposes)

- ☐ White
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Middle Eastern/North African
- ☐ 2 or More Races

What type of DENTAL INSURANCE does your student have?

- ☐ **Private Insurance** (Not eligible)
- ☐ **NO Dental Insurance**
- ☐ **Medicaid** (circle): **IL** or **IA**

Which Medicaid insurance carrier (if known):

- ☐ Envolve: Meridian/Youthcare
- ☐ Dentaquest: BCBS/Aetna/All Kids/Molina
- ☐ Other: _____

Please place Medicaid # in boxes above

My student's most recent **REGULAR DENTAL VISIT** for a **cleaning, exam, fluoride** was:

- ☐ 0-5 months (will NOT be eligible)
- ☐ 6 months or more
- ☐ Never seen a dentist
- ☐ Unsure

Has your child/teen been seen in the Give Kids a Smile Mobile Dental Clinic

- ☐ Yes
- ☐ No

TURN PAGE OVER

For Office Use: **HFS-IL says: Molina/BCBS/Aetna/All Kids/Meridian/Youthcare/Wellcare/Skygen Other: _____**

Verified Elig.: Dentaquest Envolve MCNA Delta Hawk-I other: _____ Unable to find:_____

Last Exam Date: ____/_____/_____ Sealants: Y or N SDF: Y or N (History of Sealants/SDF on back)

GIVE KIDS A SMILE — PERMISSION FORM

PLEASE CHECK IF YES

- ☐ **Needs an antibiotic premedication & why:**_____
- ☐ Behavioral Concerns:_____
- ☐ Asthma:
  - Triggers: _____
  - Inhaler Location:_____
- ☐ Cancer
- ☐ Chronic Sinusitis
- ☐ ADD/ADHD
- ☐ Autism/Spectrum Disorder
- ☐ Bleeding disorder/Anemia (circle)
- ☐ Head Injury: specify below
- ☐ Heart Condition: specify below
- ☐ **Medication** — Please list

_____

_____

- ☐ Nut Allergy
- ☐ Latex Allergy
- ☐ Metal Allergy
- ☐ Pregnancy
- ☐ Speech/Hearing Difficulties (circle)
- ☐ Fainting/Dizziness
- ☐ Tobacco/Drug Use
- ☐ Diabetes
- ☐ Epilepsy
- ☐ HIV/AIDS
- ☐ Concerns with mouth/teeth:

_____

For Office Use Only

Sealants Placed:

- ☐ 2 ____/____/_____
- ☐ 3 ____/____/_____
- ☐ 14 ____/____/_____
- ☐ 15 ____/____/_____
- ☐ 18 ____/____/_____
- ☐ 19 ____/____/_____
- ☐ 30 ____/____/_____
- ☐ 31 ____/____/_____

SDF Placed:

Tooth#____
Date: ___/___/_____
Tooth#____
Date: ___/___/_____
Tooth#____
Date: ___/___/_____
Tooth#____
Date: ___/___/_____
Tooth#____
Date: ___/___/_____

Health History Reviewed by Dentist/RDH/EFDA:

Dentist initials: _____ RDH/EFDA initials: _____

PLEASE READ THE CONSENTS BELOW:

I give permission for my student to receive dental treatment and allow the school nurse, school representative, and dental provider to access their dental record.

I give permission to Bethany for Children & Families to phone, text and/or email me regarding my student's health information.

I understand that in the rare circumstance that Bethany for Children & Families needs to transport my student from his/her school to the mobile dental clinic I will be contacted for verbal consent. (There are times that we split the day with a nearby school and your child may need to be transported by an authorized Bethany representative to the location of the mobile dental clinic.)

I give permission for Bethany for Children & Families to release, obtain, or exchange information manually and/or via an electronic platform with the I-Smile Program and/or other dental provider.

I give permission for my student's sealants to be checked and resealed if needed. (These are called IDPH Quality Assurance Audits.) They are performed by professional providers that may need to return to my student's school to recheck his or her sealants and reseal if needed.

Permission and acknowledgments are valid 12 months from the date of signature. Any changes in your student's health history should be reported to the GKAS Program at 309-581-6211 or mmosenfelder@bethany-qc.org.

My signature grants permission for the above consents and authorizes the dental provider to treat and bill for services performed in the mobile dental clinic. I have received a copy of the privacy practices.

Signature for "YES": _____ **Date:** _____

Signature for **"NO"**: _____ **Date:** _____

SDF Consent: I have read and understand the risks of Silver Diamine Fluoride (SDF) application and authorize the application and reapplication of SDF if my student would benefit from the treatment. (Benefits and risks are on page 4).

Signature for "YES": _____ **Date:** _____

Signature for **"NO"**: _____ **Date:** _____