NORTHEAST MISSOURI
HEALTH COUNCIL
Partners for a lifetime of health

MOBILE DENTAL PROGRAM

The Northeast Missouri Health Council (NMHC) is excited to partner with your school to provide dental services at school during normal school hours.

The Mobile Dental Program will accept Home State, UHC Community Plan, and Healthy Blue. There is no cost or financial requirement to the parent if the student is covered by one of these plans. If the child is uninsured, NMHC staff will work with the parent/guardian to verify eligibility and/or apply for appropriate coverage, if applicable.

The attached packet must be filled out and returned to the school nurse before the child can be scheduled on the mobile unit. The consent form in this packet must be signed by a parent or guardian.

MOBILE DENTAL PROGRAM is scheduled to be at your school during the school year. Appointments are limited, so please return completed forms to the school nurse ASAP as priority is given to students who return the completed paperwork promptly, as well as those who have the greatest dental needs. If you have questions, please contact your school nurse or the school office. We look forward to working with you and your child!

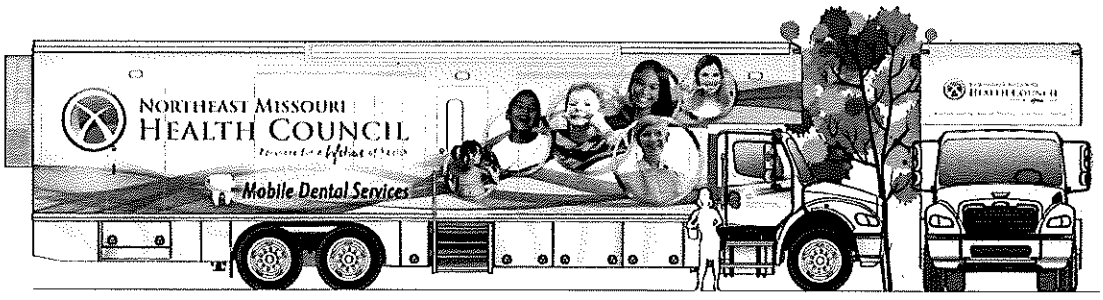
Northeast Dental
402 W. Jefferson St.
Kirksville, MO 63501
660.665.2741

Kahoka Dental
248 N. Morgan St.
Kahoka, MO 63445
660.727.1500

Macon Dental
209 N. Missouri St.
Macon, MO 63552
660.395.5045

Regarding precautions for COVID-19: *Safety for the staff and students is NMHC's main priority. We will be taking every precaution possible to ensure a safe and sterile environment for the children who receive services on the mobile unit.*

Please return completed packets to your school ASAP!



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Consent to Treat/Mobile Dental Unit/Parent Not Present

_____ _____/_____/_____
Child's Name DOB

_____
Child's School

This document is my consent as parent/guardian of the above-named child for any treatment or procedure deemed necessary by the professional staff of Northeast Missouri Health Council while my child is on the MOBILE DENTAL UNIT.

These treatments and procedures include, but are not limited to, dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays, crowns, pulp treatments, and extractions.

Please list any specific limitations for this authorization: _____

_____.

_____ _____
PRINTED Parent/Guardian Name Relationship to Patient

_____ _____/_____/_____
Parent/Guardian Signature DATE

NORTHEAST MISSOURI
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PATIENT INFORMATION

Date____/____/____	School:	
Grade:	Teacher:	
CHILD'S INFORMATION		
FNAME:	M.I.	LNAME:
DOB: ____/____/____	Age:	Gender:
Mother's Maiden Name:		Preferred Language:
Child's Primary Doctor:		Child's Primary Dentist:
Does child have prescription drug coverage? Yes or No		Preferred Pharmacy:
Is the child homeless or displaced? Yes or No		Child's race and ethnicity:
PARENT/GUARDIAN CONTACT INFORMATION		
Parent/Guardian Name:		Parent/Guardian DOB: ____/____/____
Address:		Parent/Guardian SS#: _____-____-_____
City/State/Zip:		
Primary Phone #: ( ) _____-_____ ***is this a cell # Y or N***		Alternate Phone #: ( ) _____-_____
EMERGENCY CONTACT INFORMATION		
Name of Emergency Contact (other than parent):		Relationship to Child:
Phone # of Emergency Contact: ( ) _____-_____		
INSURANCE INFORMATION		
Is Child Covered by Missouri MEDICAID/Mo HealthNet (including Healthy Blue, United Healthcare Community Plan, and Home State Health Plan?) YES or NO		
If **YES**, what is the MEDICAID #/DCN?		
Circle type if known: Healthy Blue United Healthcare Community Plan Home State Health Plan		
Is child covered by OTHER DENTAL INSURANCE? YES or NO ***(fill out as much information as known about other dental insurance below)***		
If YES, what is the type/name?		
Policy #:	Group #:	
Address to mail claims:		
Policy Holder Name:		
Policy Holder DOB: ____/____/____		Policy Holder SS#: _____-____-_____
Policy Holder Relationship to Child:		

NORTHEAST MISSOURI HEALTH COUNCIL

Partners for a Lifetime of health

Date:_____

Patient Name: DOB: Gender:

Address: Phone: Work phone:

MEDICAL HISTORY

Name of Physician: Phone:

When was your last physical?

Are your immunizations up to date? yes / no

Are you now under the care of a physician? yes / no

If yes, for what reason?

Are you presently taking any medications/drugs/pills? yes / no

Please list:

Have you ever had to be **pre-medicated** before dental treatment? yes / no

Have you ever or are you currently taking any **blood thinner** medications? yes / no

(ie. Plavix, Xarelto, Eliquis, Pradaxa, Coumadin, Warfarin)

Have you ever or are you currently taking any medication for:

osteoporosis, cancer or rheumatoid arthritis? yes / no

Have you ever or are you currently taking an **oral or IV Bisphosphonate or any of the following medications? (ie. Actonel, Boniva, Fosamax, Didronel, Prolia, Zometa)** yes / no

Are you **allergic** (or have an adverse reaction) to? **(circle all that apply below)**

Penicillin Other Antibiotic **Local Anesthetic** **Epinephrine** Aspirin None

Codeine **Latex** Other Please describe:

Are you sensitive or allergic to latex? yes / no

(i.e. Experienced itching, rash or wheezing after using latex gloves or handling a balloon)

Do you have, or have you had any of the following: (Check boxes that apply.)

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Artificial Joint
- ☐ Anorexia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autism
- ☐ Blood Clotting disorder
- ☐ Blood Transfusion
- ☐ Bulemia
- ☐ Cancer
- ☐ Chemo/Radiation Therapy
- ☐ Cognitive Disability
- ☐ Congenital Heart Defect
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Food Allergies
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pain Management
- ☐ Recurring Otitis/Ear Infect.
- ☐ Recurring Strep
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Shingles
- ☐ Vision Impairment/Problems
- ☐ Wheezing
- ☐ Family Hx of Von Williebrand
- ☐ Hearing Impaired
- ☐ MRSA
- ☐ Neurological Disorders
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ STD/STIs
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Surgical History:

Have you had any of the following surgeries listed below? **(circle all that apply below)**

Adenoidectomy Ear tubes Fundoplication Gastrostomy tube
Heart Surgery Joint Replacement Organ Transplant Prosthetics/Rods/Pins
Removal of Spleen Tonsilectomy VP Shunt

Have you had any of the other surgeries, hospitalizations or illness not listed above?

If yes, please explain: _____

Have you had any unusual or unexplained reactions during a surgical procedure? yes / no

If yes, please explain: _____

Do you currently smoke or use the following tobacco products? yes / no

Cigarettes Cigars Pipe Chew Vaping/E-Cigarettes

Have you used tobacco products in the past? yes / no

If yes, how long ago? _____

Do you drink alcoholic beverages? yes / no

If yes, how much? _____

WOMEN: Are you pregnant? yes / no

Are you nursing? yes / no

Do you take birth control medications? yes / no

Do you anticipate becoming pregnant? yes / no

DENTAL HISTORY

Date of Last Dental Visit: _____ OR UNKNOWN

Have you experienced/Are you experiencing any of the following? **(Check all that apply.)**

- ☐ Bleeding Gums
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity to sweets/sour
- ☐ Pain w/teeth
- ☐ Sores in/around mouth
- ☐ Head/neck/jaw injury
- ☐ Frequent headaches
- ☐ Clench/grind teeth
- ☐ Bite lips/cheeks frequently
- ☐ Clicking in jaw
- ☐ Pain (joint, ear, side of face)
- ☐ Difficulty in opening or closing mouth
- ☐ Difficulty in chewing
- ☐ Orthodontic work
- ☐ Prolonged bleeding following extraction

Have you ever had instruction on the correct method of brushing your teeth? yes / no

Have you ever had instructions on the care of your gums? yes / no

HIPAA & INS/TX AUTH – Mobile Dental Unit

NORTHEAST MISSOURI HEALTH COUNCIL
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PATIENT NAME_____ **DOB** _____/_____/_____
(Please Print)

NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used for: **treatment, payment, and healthcare operations.** NMHC'S NOTICE of PRIVACY PRACTICES is posted in each clinic reception area, is available from any front desk associate, and can be viewed online at nemohealthcouncil.com. I understand Northeast Missouri Health Council, Inc. (NMHC, Inc.) has the right to change its Notice of Privacy Practices from time to time. My signature below indicates I have read and understand NMHC's Notice of Privacy Practices.

Patient/Guardian Signature_____ **Date** _____/_____/_____

ASSIGNMENT OF INSURANCE BENEFITS & TX AUTH:

I, the undersigned, authorize my insurance benefits to be paid directly to the provider of the Northeast Missouri Health Council, Inc. (NMHC, Inc.), for services rendered. I understand that I am ultimately financially responsible for any balance due not paid by insurance. I hereby authorize NMHC, Inc., to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

I, the undersigned, consent to Northeast Missouri Health Council providers and staff to perform medical/dental examinations, testing and treatment as directed by my provider. I understand that I have the right to discuss with my provider the purpose, potential risks, and benefits of any ordered tests or treatment options. I understand that if invasive or interventional tests or procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures. I understand that the consent will remain fully effective until it is revoked in writing.

Patient/Guardian Signature_____ **Date** _____/_____/_____

1. Circle the NUMBER of people in your household.
2. Follow that number across to the column closest to your household income and circle that LETTER.
3. Anyone between letters A-E may be eligible for our SLIDE program with appropriate income documentation. Category F is overqualified for SLIDE.

Household Size	A	B	C	D	E	F
1	0 - 13,590	13,591 - 16,988	16,989 - 20,385	20,386 - 23,783	23,784 - 27,179	27,180 & above
2	0 - 18,310	18,311 - 22,888	22,889 - 27,465	27,466 - 32,043	32,044 - 36,619	36,620 & above
3	0 - 23,030	23,031 - 28,788	28,789 - 34,545	34,546 - 40,303	40,304 - 46,059	46,060 & above
4	0 - 27,750	27,751 - 34,688	34,689 - 41,625	41,626 - 48,563	48,564 - 55,499	55,500 & above
5	0 - 32,470	32,471 - 40,588	40,589 - 48,705	48,706 - 56,823	56,824 - 64,939	64,940 & above
6	0 - 37,190	37,191 - 46,488	46,489 - 55,785	55,786 - 65,083	65,084 - 74,379	74,380 & above
7	0 - 41,910	41,911 - 52,388	52,389 - 62,865	62,866 - 73,343	73,344 - 83,819	83,820 & above
8	0 - 46,630	46,631 - 58,288	58,289 - 69,945	69,946 - 81,603	81,604 - 93,259	93,260 & above
	add $4,720 per	*add $5,900 per*	*add $7,080 per*	*add $8,260 per*	*add $9,440 per*	

**For families with more than 8 members add the appropriate figure noted in each column per additional member.*

As a Federally Qualified Health Center (FQHC), NMHC is required to request socioeconomic data on our patients. Please circle your **household size** (NUMBER) and the approximate **annual income category** (LETTER) on the chart below, such as 1A or 4D, etc. NMHC, Inc., appreciates your cooperation and assures you we only report ***de-identified*** (no names or medical information) data. **fye2023**