Kids First Dental Care

119 Pine Street, Barbourville, KY 40906
(606) 546-7410
www.kidsfirstdental.org

GET HEALTHY Kentucky
UNBRIDLED SPIRIT

KIDS FIRST DENTAL CARE

Mobile Dental Program

www.kidsfirstdental.org

Barbourville, Kentucky
Phone: (606) 546-7410 Fax: (606) 545-7261

We are pleased to introduce Kids First Dental Care. Our organization will provide a comprehensive dental exam for your child. Upon completion of the exam we will provide you with a treatment plan of your child's needs. We plan to not only address current needs but also reduce future needs, by early detection and preventive care.

Attached you will find a consent form for parents' signature requesting our services. We will bill all insurance including Medicaid and private carriers. All children with a completed form will be examined regardless of their ability to pay and at no time will any child, parent, or school be billed.

This examination is for diagnostic and preventive purposes only. **No treatment such as fillings, root canals, or extractions will take place as part of this program.**

Please complete the attached form and sign where indicated. We must have this completed and signed before we can provide this service for your child.

Thank you very much for working with our schools to help prevent dental disease. If you have any questions please call our office at (606) 546-7410.

This notice is pertaining to the new law that protects the privacy of your child's patient information for dental services rendered by KIDS FIRST DENTAL CARE, LLC

NOTICE OF PRIVACY PRACTICES

KIDS FIRST DENTAL CARE, LLC
119 Pine St. Barbourville, KY 40906

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Used and Disclosures of Health Information – We may use health information about you for treatment (such as sending your medical record information to a specialist and as part of a referral), to obtain payment for treatment (such as sending billing information to a health/dental insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

We may use or disclose identifiable health/dental information about you without your authorization for several reasons. Subject to certain requirements, we may give out health/dental information without your authorization for public health purposes. Abuse or neglect reporting, auditing purposes, judicial and administrative proceedings, research studies, specialized government functions, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also initiate a face-to-face communication with you about goods and services related to our care and provide you with promotional gifts of nominal value. In any situation, we will ask for your written authorization before using or disclosing any identifiable health/dental information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change, you will be notified prior to your next annual exam. You may request a copy of our notice at any time.

Individual Rights – In most cases, you have the right to review or receive a copy of health/dental information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You have the right to request that your health/dental information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice. You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints – If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

Our Legal Duty – We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact: Stephanie Smith at the address above or call 1-606-546-7410.

ACKNOWLEDGEMENT

Please remove this notice and keep for your records. Sign the Patient Privacy Notice on the consent form as receipt you received this notice.

Official Use Only

Elg. Period _____

Last Pro _____

KIDS FIRST DENTAL CARE

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119 Pine Street - Barbourville, Kentucky 40906
Phone: (606)546-7410 Fax: (606)545-7261

Child's School _____

County _____

Patient Information

PLEASE DO NOT FILL OUT FORM IF NOT INTERESTED IN SERVICE

CHILD'S NAME _____ ☐ Male ☐ Female
LAST FIRST M

PARENT'S NAME _____ ☐ Mother ☐ Father ☐ Guardian

ADDRESS _____

CHILD'S BIRTHDATE _____ HOME PHONE _____ WORK _____ CELL _____

CHILD'S SS# _____ TEACHER _____ GRADE _____

Medicaid Number / KCHIP Number

☐ **My Child Has Dental Insurance**

☐ **My Child Is Uninsured and I Am Interested In KCHIP - (877) 524-4718**

From time to time, we photograph patients for use in advertising, news stories and publicity materials used to promote the Kids First Dental Care program.

If you do **not** want your child to be photographed for possible use in our promotional materials, please check this box. ☐

PRIMARY INSURED (Not Child) Not for Medicaid/KCHIP

Last First Middle

Street City State Zip

Home Work Cell

Birthdate (Mo/Day/Year) Relationship to Child

Employer Dental Insurance Company Phone

Dental Insurer's Address

SS # Subscriber # Group #

Medical/Dental Information

CHILD'S DOCTOR'S NAME _____ PHONE _____
CHILD'S DENTIST OF RECORD _____ PHONE _____

DOES YOUR CHILD HAVE A SPECIFIC DENTAL PROBLEM? (describe) _____	☐ Y ☐ N
DOES YOUR CHILD HAVE DENTAL EXAMINATIONS ON A REGULAR BASIS (Y/N)? Date of last exam? _____	☐ Y ☐ N
IS YOUR CHILD UNDER A PHYSICIAN'S CARE NOW? If so, why? _____	☐ Y ☐ N
HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION? (discuss) _____	☐ Y ☐ N
IS YOUR CHILD TAKING ANY MEDICINES (pills or drugs)? If so, what? _____	☐ Y ☐ N
IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? (please identify) _____	☐ Y ☐ N
DOES YOUR CHILD HAVE A MENTAL OR PHYSICAL DISABILITY? (please identify) _____	☐ Y ☐ N

WOMEN: ARE YOU... (check all that apply) ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives (discuss) _____

HAS YOUR CHILD—NOW OR EVER—HAD ANY OF THE FOLLOWING? (check all that apply)
If you checked any of the below conditions with an asterisk (*), PLEASE CALL PRIOR TO YOUR APPOINTMENT. Pre-medication may be required.

☐ HEART DISEASE/HEART SURGERY*	☐ FEVER BLISTERS	☐ HEPATITIS-A (infectious)	☐ ANEMIA
☐ MITRAL VALVE PROLAPSE*	☐ SICKLE CELL DISEASE	☐ HEMOPHILIA (bleeding problems)	☐ ASTHMA
☐ ARTIFICIAL HEART VALVE*	☐ LUNG DISEASE	☐ STOMACH/INTESTINAL DISEASE	☐ DIABETES
☐ ARTIFICIAL JOINT*	☐ LIVER DISEASE	☐ EPILEPSY OR SEIZURES	☐ HIV-POSITIVE
☐ RHEUMATIC FEVER*	☐ KIDNEY PROBLEMS	☐ ALLERGIES (pollen/dust)	☐ PSYCHIATRIC CARE
☐ TUMORS OR GROWTHS	☐ NEED PRE-MEDICATION		

I Give Kids First Dental Care (KFDC) Associates permission to treat my child with exam, X-rays, sealants, cleaning, and fluoride treatment and by signing below, I acknowledge that I have received KFDC Notice of Privacy Practice and have been offered an opportunity to request restrictions on certain uses and disclosures of my Child's personal health information. As the parent/guardian of the student named above, I authorize KFDC to disclose to the school nurse or other school representative the following health information about the Student: Any and all medical and dental care information regarding dental exams performed by KFDC. The information will be disclosed to the school in order that the School may address any dental problems that may affect the Student's education. By providing this authorization, I understand that this Authorization is voluntary. KFDC may not condition the Student's treatment, payment, or eligibility for benefits on my signing this Authorization. I understand that the health information to be released may be subject to re-disclosure by the School. I understand that I may revoke this Authorization at any time by notifying KFDC in writing, but if I do it will not have any effect on disclosures made prior to the receipt of the revocation.

Parent/Guardian Signature X _____ **Date** _____

TX COMPLETED _____

☐ Extra-Oral ☐ Intra-Oral ☐ Head/Neck Eval ☐ Cancer Eval ☐ Occl Eval

Dr. Signature Date

	DATE	INITIALS
X-RAYS		
CHARTED		
POSTED		
TX PLAN		
PATIENT ED.		

Existing	Tooth Number	Tx Plan