

PRASAD®

Philanthropic Relief, Altruistic Service And Development

Children's Dental Health Program



Participating Districts:

Fallsburg CSD
Liberty CSD
Livingston Manor CSD
Monticello CSD
Roscoe CSD
Sullivan BOCES
SC Head Start
Sullivan West CSD
Tri-Valley CSD

We Bring Dental Services to Your School!

No more taking days off or traveling to the Dentist Office

Our mobile clinic is **fully equipped with two dental offices** that allows us to provide: dental exams and an array of dental treatments including sealants, cleanings, fluoride, fillings, extractions, space maintainers and x-rays.

New & Existing Patients Welcome!

WHO IS ELEGIBLE TO RECEIVE SERVICES? Children ages six months through 18 years of age who are **NOT** assigned or receiving services from another dental office.

If a parent/guardian would like to make PRASAD their dental provider, the parent/guardian must contact their insurance company and request that PRASAD become their dental provider. **PRASAD accepts most insurance plans including Medicaid, Delta Dental, Fidelis, and MVP. A sliding fee application is available for uninsured children.**

HOW CAN I MAKE AN APPOINTMENT?

You can make an appointment by calling our office at (845) 434-0376 ext. 216. In addition, the school will send an application form home with all students before the clinic's visit.

Our dental clinic visits Sullivan County schools on a rotating basis. It is possible to arrange an appointment when the clinic is not at your local school site or during the school holidays. The clinic is also open during the summer at our main office in Ferndale.

Mission: Improve the quality of life of children by providing oral care services and dental health education.

**Call for an Appointment
(845) 434-0376 ext. 216**

Parents/legal guardians must sign and return the application, showing consent for treatment before their child can be seen in the clinic.

For more information about PRASAD visit www.prasadcdhp.org



IF YOUR CHILD WAS EXAMINED THIS SCHOOL YEAR YOU HAVE ALREADY CONSENTED FOR RE-EXAMINATION

CONSENT FORM PLEASE COMPLETE WITH INK SECTIONS 1 – 5 AND RETURN TO THE TEACHER

1. Your child's information

Child's Name _____ Birth date _____
 Parent's Name _____
 Address _____ Zip Code: _____
 Telephone (day) _____ (evening) _____
 Emergency phone: _____ School _____
 Sex: F ___ M ___ Grade ___ Race: _____

2. Your child's dental insurance

Medicaid ID# _____
 Other (Wellcare, Fidelis, Healthplex MVP) _____
 Delta Dental, ID # _____
 I do not have dental insurance, and would like to be contacted regarding the Sliding Fee
 Date of last dental visit: _____

3. Health History

If you don't know or are not sure of the answer to any of these, please call or visit the Mobile Dental Clinic as we cannot provide care without all of this information

- Who is your child's medical doctor? _____ Phone: _____
- Is your child taking any medicine(s)? ___ YES ___ NO ___
 If yes, what medicine and for what purpose? _____
- Has your child ever had any of the following? Please check appropriate box

- | | | | |
|--|--|---|--|
| Heart Murmur <input type="checkbox"/> | Radiation Treatment <input type="checkbox"/> | Sinus Trouble <input type="checkbox"/> | Cancer or Tumors <input type="checkbox"/> |
| Autistic <input type="checkbox"/> | Asthma <input type="checkbox"/> | Emotional Problems <input type="checkbox"/> | Lung Disease <input type="checkbox"/> |
| Epilepsy/Seizure <input type="checkbox"/> | Prolonged Bleeding <input type="checkbox"/> | Sickle Cell Anemia <input type="checkbox"/> | HIV or AIDS <input type="checkbox"/> |
| Hemophilia <input type="checkbox"/> | Liver Disease (Hepatitis) <input type="checkbox"/> | Pneumonia <input type="checkbox"/> | Artificial Joint <input type="checkbox"/> |
| Heart Disease <input type="checkbox"/> | Measles <input type="checkbox"/> | Jaundice <input type="checkbox"/> | Hives <input type="checkbox"/> |
| Convulsions <input type="checkbox"/> | Chicken Pox <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> | Physical Handicap <input type="checkbox"/> |
| Blood Transfusion <input type="checkbox"/> | Hay Fever <input type="checkbox"/> | Fainting <input type="checkbox"/> | Thyroid Problems <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Arthritis <input type="checkbox"/> | Ulcer or Colitis <input type="checkbox"/> | Kidney Problems <input type="checkbox"/> |
| Anemia <input type="checkbox"/> | Bladder Problems <input type="checkbox"/> | Mumps <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| Speech/Hearing Problems <input type="checkbox"/> | Whooping Cough <input type="checkbox"/> | Eye Problems <input type="checkbox"/> | Cleft Lip/Palate <input type="checkbox"/> |
| Tonsillitis <input type="checkbox"/> | | | |

- Are your child's immunizations up-to-date? ___ YES ___ NO ___
- If no, please explain _____
- Has your child ever had an allergic reaction? ___ YES ___ NO ___

If yes, please explain _____

I understand that in the event there is any change in my child's health status, I will notify your office at the earliest possible time.

Required

4. Parent/Guardian Signature X: _____ Date _____

We will schedule your child during regular school hours. However, if you wish to be present at his/her appointment or if you have any questions, please call (845) 866-4562 or our Main Office at (845) 434-0376 x 216.

PLEASE COMPLETELY FILL OUT THIS FORM AND RETURN IT TO THE SCHOOL!

CONTINUE →

CONSENT AND WAIVER

Child's Name _____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate.

I give consent for my child to receive a dental check-up including x-rays and cleaning. If my child requires any additional dental treatment, the dentist will provide these services which may include any or all of the following: fillings, extractions, crowns, and pulp therapy. I understand that I will be notified before any additional work is started. I also understand that it may not be possible to do all the needed treatment on the mobile dental clinic.

The risks associated with treatment are: accidental biting or scratching of the lip/cheek by the child if local anesthesia "novocaine" is used; temporary discomfort, swelling or bleeding. If no treatment is received, undetected dental/oral disease may lead to pain, swelling, infection or tooth loss.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S INSURANCE COVERAGE, OTHERWISE I MAY BE FINANCIALLY RESPONSIBLE FOR SOME OF THE CHARGES REGARDING SERVICES PROVIDED TO MY CHILD.

I expressly release PRASAD Children's Dental Health Program, Inc., its directors, officers, agents, representatives, licensees, successors, and assignees from any and all claims (including right of publicity, right of privacy, performance rights and copyrights) which I have or may have arising out of production, reproduction, use, broadcast, exhibition, distribution, or promotion of any portion thereof.

I also consent to having my child's doctor release my child's medical record to PRASAD Children's Dental Health Program, Inc. if my child's health history shows health problems that may affect his/her dental treatment on the mobile dental clinic. In addition, I consent to having PRASAD Children's Dental Health Program release and receive any and/or all information related to my child's health status to and from the Sullivan or Ulster County Department of Family Services and other social service or health care providers.

Recent HIPPA regulations focus on protecting patient confidentiality. One component of the regulations prohibits leaving messages on patient answering machines. I understand that in order to offer a best possible service, it is necessary to utilize answering machines. I authorize PRASAD Children's Dental Health Program and its representative to leave information on my answering machine for services such as reminder for treatment, appointments, confirmation of information or returning your phone call.

I understand that the consent shall remain in effect until I choose to end it, and that I am free to withdraw my consent at any time by written notification to PRASAD Children's Dental Health Program, Inc. I have read and understand this consent form, and have asked questions that I had, and all questions have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions which may come up during the course of my child's treatment, and that there are no guarantees regarding any treatment results. I understand that I will receive a final report on all treatment received at the clinic.

I hereby authorize the release of any medical /dental information to the Insurance Co., and third party billed, necessary to process my Ins. Claims. I assign the payment of dental benefits payable to: PRASAD Children's Dental Health Program, Inc. 465 Brickman Road, Hurleyville, NY. 12747.

I represent that I am the legal guardian of the above named child and that I have the legal authority to make health care decisions on the child's behalf. If my child receives dental care, I waive any claims, which I may have against the program provider, namely, PRASAD Children's Dental Health Program, Inc., its agents, directors, officers, or employees as a result of the performance of said services.

This consent and waiver shall be binding on my executors, administrators, heirs, legatees and assignees and shall be construed and enforced according to the laws of the State of New York, USA, exclusive of its choice of law rules.

Required

5. Parent or Guardian Signature X : _____ **Date** _____

Relationship to Child _____