University at Buffalo
School of Dental Medicine

S-Miles To Go Mobile Dental Program

UB's ***S-MILES TO GO DENTAL PROGRAM*** will be visiting your child's school soon. If you do not have a dentist this is a great opportunity for your child to receive dental care during the school day.

WHAT IS IT?

UB ***S-MILES TO GO DENTAL PROGRAM*** (Dental Van) offers the following dental services to your children:

- A new 3 chair mobile dental office that will be parked at the school
- Examinations, x-rays, cleanings, sealants, fillings and other dental services
- Specially trained Pediatric and General Dentists
- If your child has dental insurance, the insurance carrier will be billed for these services described above. If you do not have dental insurance or cannot afford dental care, UB Dental has a sliding fee program to assist you. Please call 716-829-6240 to make payment arrangements to avoid receiving a bill. Our goal is to provide dental services to all regardless of ability to pay.

HOW DOES IT WORK?

- Complete the attached consent form. Please include insurance information and check just one box indicating the services you wish your child to receive. Don't forget to sign the form.
- Medicaid, Child Health Plus and Family Health Plus Insurances will be billed for services and are accepted as payment in full. Private insurance please call 716-829-6240 for instructions.
- Dental screening and oral health education are provided at no charge to you and a screening report form will be sent home.
- Treatment is provided to your child during the school day on the *S-Miles To Go* dental van or in the school with portable dental equipment.
- Parents are welcome to attend the appointment but it is not necessary.

WHAT'S NEXT?

Child's Name:_____Grade_____Teacher_____

⬭ **YES, I want my child to receive dental care**

If yes, to sign your child up for the S-miles To Go mobile dental program please complete the attached paperwork and return it to your child's teacher as soon as possible.

⬭ **NO, I do not want my child to receive dental care, my child sees a dentist regularly.**

If No, Please return this form to your child's teacher to avoid further communication. Thank You!

QUESTIONS?

- Contact the Intake Coordinator at 716-970-6343, the MDU at 716-560-5127 or Paula Fischer at UB, 716-829-6240 or pmfische@buffalo.edu

Poor oral health can lead to decreased school performance, poor social relationships and less success later in life. Children experiencing oral pain are distracted and unable to concentrate on schoolwork. UB Dental is here to help your child succeed.

Revised 8/5/2022

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S-Miles To Go Mobile Dental Program

School: _____ Grade: _____ Age: _____ Teacher: _____

Patient Information

Date: ___ ___/ ___ ___ / ___ ___

Last Name: First Name: Middle Initial:

Birthdate: / / Social Security Number: Gender: Male Female

Address: City: Zip Code:

Email: Home Phone#: Cell #:

Financially Responsible Party - Primary Parent / Guardian

Last Name: First Name: Middle Initial:

Relationship: ☐ Mother ☐ Father ☐ Legal custodian – Relationship: ☐ Custody Paperwork Provided
Gender: Male Female

Primary Language: **Do you need an interpreter** ☐ Yes ☐ No

Social Security Number: Birthdate: / /

Address (if different from above): City: Zip Code:

Email: Home Phone#: Cell #:

Secondary Parent / Guardian (Optional)

Last Name: First Name: Middle Initial:

Relationship: ☐ Mother ☐ Father ☐ Legal custodian – Relationship: ☐ Custody Paperwork Provided
Gender: Male Female

Social Security Number: Birthdate: / /

Address (if different from above): City: Zip Code:

Email: Home Phone#: Cell #:

Emergency Contact Information

Name: Relationship:

Address: Phone #:

City: State: Zip:

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race ☐ Decline

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Decline

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Physician & Pharmacy Information		
Pharmacy Name:	Address:	Phone Number:
Physician Name:	Phone Number:	Date of last visit:
Previous hospitalizations in the past 5 years/surgeries/ER Visit /serious illnesses? If yes, how long ago?		

Health Information:

- **Is Your Child in Good Health?** ☐ Yes ☐ No
- **If No, Explain:** _____

Has there been any change in your child's health in the past year? ☐ Yes ☐ No

- **If Yes, Explain:**

_____

- **Allergies (**Food, Seasonal, Medication) _____ ☐ Yes ☐ No

Are your child's immunizations up to date? ☐ Yes ☐ No

- **Are there any health conditions that necessitate your child taking medication Prior to dental treatment?** ☐ Yes ☐ No
- **Please list all Medications, supplements, vitamins, natural or herbal that your child is taking.**

_____

- Is your child now, or has been in the past year, under the care of a physician? ☐ Yes ☐ No
- Has your child had an organ transplant? If yes, specify: _____ ☐ Yes ☐ No
- Has your child had open heart surgery? If yes, specify: _____ ☐ Yes ☐ No
- Has your child had an orthopedic total joint replacement? If yes, specify _____ ☐ Yes ☐ No
- Has your child ever had any radiation therapy or chemotherapy for any growth, tumor or other condition? (Specify) _____ ☐ Yes ☐ No
- In the last 2 years, has your child taken or are they now taking steroids (e.g. Cortisone)? ☐ Yes ☐ No
- Has your child taken, are taking or scheduled to begin taking oral bisphosphonates (Alendronate, (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Or Tiludronate (Skelid)? (Specify) _____ ☐ Yes ☐ No
- Has your child taken, are taking or scheduled to begin taking intravenous bisphosphonates (Clodronate (Bonefos), Pamidronate (Aredia) or Zoledronic Acid (Reclast, Zometa)? ☐ Yes ☐ No (Specify) _____

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- What is your child's current overall smoking status?

1 Pack of cigarettes or more a day Any Vaped nicotine Smokes any quantity but not daily

1 cigar or more a day Less than a pack of cigarettes Former smoker Never smoked

- Does your child use snuff, chew, bidis? (Specify) _____ ☐ Yes ☐ No
- Does your child drink alcoholic beverages, if yes, how often? _____ ☐ Yes ☐ No
- Does your child use prescription or street drugs or other substances for recreational purposes? (Specify) _____ ☐ Yes ☐ No

FEMALES ONLY:

- Is your child Pregnant? ☐ Yes ☐ No
- Is your child Nursing? ☐ Yes ☐ No
- Is your child taking birth control pills, fertility drugs or hormonal replacement? (Specify) _____ ☐ Yes ☐ No

Does your child have any of the following diseases or problems (if Yes circle which one)?

- Heart Disease/High Blood Pressure ☐ Yes ☐ No
- Rheumatic Fever/Rheumatic Fever Heart Disease ☐ Yes ☐ No
- Congenital Heart Defect/Heart Murmur ☐ Yes ☐ No
- Anemia/Sickle cell/Blood Transfusions ☐ Yes ☐ No
- Hemophilia/Prolonged Bleeding/Bruise easily ☐ Yes ☐ No
- HIV/Aids ☐ Yes ☐ No
- Stomach/Intestine/Liver disorder/Hepatitis ☐ Yes ☐ No
- Kidney/Urinary disorder ☐ Yes ☐ No
- Diabetes/Endocrine Disorder/Thyroid/Eating disorder ☐ Yes ☐ No
- Cancer/Tumors ☐ Yes ☐ No
- Dermatologic /Skin Problem ☐ Yes ☐ No
- Speech or Hearing-Impaired ☐ Yes ☐ No
- Neurologic/Nerve Problems: ADD, ADHD, Cerebral palsy, Mental health disorder ☐ Yes ☐ No
- Epilepsy/Seizures: Convulsions, Fainting or dizzy, Loss of consciousness ☐ Yes ☐ No
- Respiratory/Lung Problem: Asthma, Bronchitis, Pneumonia, Tuberculosis ☐ Yes ☐ No
- Growth/Development: Developmental delay/Genetic disorder/Premature birth/Pregnancy Complications, Behavioral problem, Excessive nervousness, Learning disability ☐ Yes ☐ No
- Head/Eye/Ear/Nose/Throat problem ☐ Yes ☐ No
- Muscle/Bone/Connective Tissue disorder ☐ Yes ☐ No
- Infectious disease ☐ Yes ☐ No
- Other ☐ Yes ☐ No

Anything not listed or If Yes, explain:

_____

_____

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UB Dental Provider's Signature: _____

Previous Dentist If any: _____

IS THIS YOUR CHILD'S FIRST DENTAL VISIT? ☐ Yes ☐ No ☐ Not Sure

When was the last time your child had dental care?

Please Circle: Within 1 year 1-3 years Over 3 years

DOES YOUR CHILD HAVE ANY EXISTING DENTAL PROBLEMS/CONCERNS (toothache, loose tooth, swelling?) ☐ Yes ☐ No

If Yes, explain: _____

Dental Insurance Information:

☐ **UNINSURED for DENTAL COVERAGE (you will be contacted by program staff)**

☐ **MEDICAID INSURANCE (Please fill out information in box 1)**

☐ **OTHER DENTAL INSURANCE (Please fill out information below in box 2, Completely)**

Patient's with Insurance through Medicaid fill out the box below:

Box 1

Dental Insurance Name: _____ ID # _____
(Example: Medicaid, Fidelis, Highmark, Molina, Independent Health, etc.) (Number is on the Card)

Cin Number (Example: AB12345C) _____

Patient's with Commercial Insurance: (insurance through an employer) All fields below are required:

Box 2

Insurance Name: (example: Delta Dental) _____

Insurance Claims Address: _____
Street Address City State Zip code

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Patient: _____

- The risks associated with treatment are: accidental biting or scratching of the lip/cheek by the patient if local anesthesia is used and /or slight discomfort, bleeding and/or swelling. If no treatment is provided, the following may occur: undetected dental/oral disease (cavities, gum disease etc.), which may lead to pain, swelling, and/or infection.

- In the highly unlikely event that either the patient or a treating provider of the patient is exposed to blood and/or potentially infectious bodily fluids during treatment, I consent to my child being transported immediately to a local hospital for medical evaluation and follow-up by a Physician or Health Care Provider. I understand that while every effort will be made to inform me prior to this occurring, I understand that due to the importance of timely evaluation, I consent to this evaluation and/or treatment absent my verbal consent after potential exposure.

    - I understand that this consent may stay in effect for one year. I understand that it is my responsibility to inform the dental provider of any changes in my child's medical information

    - **I understand that all information will be kept confidential. I have read and agree to the Notice of Privacy Practices & Patient Rights & Responsibilities (available at link below).**

https://dental.buffalo.edu/patients/current-patients/patient-privacy-information.html

- If you need specialty care (sedation), you will be notified and will be referred to the UB School of Dental Medicine or a Provider of your choice.

- I further consent that my child's medical doctor and/or school official may release any medical information to the UB Dental staff that may affect his/her dental treatment. In addition, if a dentist is noted above, I understand that any dental findings/treatment shall be forwarded to that provider.

- Photographs may be taken for various purposes including use in the electronic health record, educational/teaching purposes and for marketing including print, television and internet advertisement. By consenting to release of images, you agree that you will not receive any form of compensation for the use of the image/s. Your refusal to consent to the release of patient images will not, in any way, affect the dental care received. You may rescind your authorization to the release of the photograph by submitting a request in writing.

I authorize use of Photographs for the following:

- Use of image/s for the electronic health record ☐ Yes ☐ No

- Use of image/s for educational/teaching purposes ☐ Yes ☐ No

- Use of image/s for Social Media and Online Publishing, Print Marketing, Video and Television Media Advertisements ☐ Yes ☐ No

CONSENT

In order for us to treat your child, you must sign on page 7 indicating you have read and agree to the following information:

Authorization for Treatment:

I, the undersigned, hereby authorizes the dental staff of UB School of Dental Medicine to provide dental care to my child as indicated to me on the Mobile Dental Unit. **It is my responsibility to inform the dental provider of any changes in my child's medical information by calling (716)560-5127, (716)970-6343 or (716)829-6240.**

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Financial Responsibility/Assignment of Benefits: I authorize The UB School of Dental Medicine (UBSDM) to apply for insurance benefits on behalf of my child and request the insurance company pay directly to UBSDM insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify UBSDM of any changes. **If your child has had a dental cleaning within the past 6 months and you have used your insurance, you are not eligible for insurance reimbursement at this time**. **Medicaid, and Private Insurance accepted as payment in full. You will not receive a bill if we have the correct insurance information. In the event you feel you received a bill in error, please call Paula Fischer at 716-829-6240**

I understand that by signing this form, I am consenting for the person named below to receive a dental examination, bite-wing and/or panoramic x-rays as needed, dental cleaning, brushing/flossing instructions, fluoride treatment (varnish & silver diamine), sealants, fillings and simple extractions as needed.

*****PLEASE CHECK ONE BOX ONLY*****

☐ Yes, I would like my child **to have a dental examination including x-rays (if needed), cleaning, fluoride treatment, sealants** (a coating that protects teeth from cavities), **fillings, extractions (teeth pulled) and other treatment as needed** by a licensed dental provider and/or dental student who is supervised by a licensed dental provider

OR

☐ Yes, I would like my child **to have a dental screening and oral health education (no charge to you)** by a licensed dental provider and/or dental student who is supervised by a licensed dental provider.

**** A report form will be sent home with your child****

By signing this form, I give consent for treatment and agree to the Financial Responsibilities previously listed. **I also agree to allow the University at Buffalo School of Dental Medicine (UBSDM) to bill my insurance for services rendered at the UB Mobile Dental Van and have payment made directly to the UBSDM. If payment is sent to me in error, I agree to forward to the UBSDM at the address below. Please include account number with payment.**

(Forms that do not have a signature will be returned)

UB School of Dental Medicine Billing Department
3435 Main Street
Squire Hall
Buffalo, NY 14214

Child's Name: _____ **Date of Birth:** ___ ___ / ___ ___ / ___ ___

_____ _____

Signature of Parent/Legal Guardian **Printed Name of Parent/Legal Guardian**

_____ ___ ___ / ___ ___ / ___ ___

Relationship to Child **Today's Date**

This agreement will remain in place unless subscriber requests, in writing, to have revoked.

YOU CANNOT BE SEEN FOR DENTAL CARE UNLESS THE ABOVE INFORMATION IS RECEIVED. If you need assistance completing this form please call the Mobile Dental Unit at 716-560-5127, 716-970-6343 or Paula Fischer at 716-829-6240

If you have a dental emergency Monday thru Friday between the hours of 9am-4pm, please call the Mobile Dental Unit at 716-560-5127, 716-970-6343 or UB School of Dental Medicine 716-829-2824. After hours or on the weekend, proceed to your nearest emergency care facility. The UB School of Dental Medicine is not responsible for reimbursement of any charges you incur while obtaining emergency dental care at any other facility.

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