

Arcado Elementary School

Easy Steps for Parents to Get
Dental Services for Their Child



Welcome Parents!

- Norcross Health Center will provide dental services for your child if you have Medicaid, or no insurance at all!

Norcross Health Center
5030 Georgia Belle Court Suite 2071
Atlanta, GA 30341
770.638.5758



Norcross Health Center

Our Hours

Monday | 8:00 AM - 5:00 PM
Tuesday | 8:00 AM - 5:00 PM
Wednesday | 8:00 AM - 5:00 PM
Thursday | 8:00 AM - 5:00 PM
Friday | 8:00 AM - 5:00 PM
Saturday | Closed
Sunday | Closed

Dental Care Services

- The below services are available:

- Exams
- Sealants
- X-rays
- Fluoride Treatments
- Fillings
- Education on preventing dental disease
- Treatment of oral infections
- Dental screenings and oral examinations
- Teeth cleanings
- Sealants on permanent molars
- Extractions of non-restorable teeth
- Referrals for sedation dentistry and orthodontic treatment

Schedule an appointment

- Call 770-638-5758 and speak to **Patricia**
- The answering message is in English and Spanish
- Leave a message to set an appointment if no one answers
 - 1st appointments include:
 - Cleaning
 - Exam
 - X-rays (6-19 yrs)
 - Fluoride treatment



Charges for services

Parents can ask for prices before and during appointments:



Medicaid

- If the child has Medicaid, they will bill Medicaid

Non-insured

- Charged a discounted rate
 - 1-5 yrs \$130-140
 - 6-19 yrs \$160-170

Ask questions
before you leave
appointment!

3 Forms to complete

#1 Dental Eligibility and Medical History Form

Dental Eligibility and Medical History Form

 **Welcome!** Medical Alert: _____
Patient No.: _____

Please use Ink!

We are pleased to welcome you to Georgia Public Health! Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your child's dental health!

Child's name: _____ Birthdate: ____/____/____
Last First Middle

Age: _____ Sex: _____ Race: _____

Address: _____ County: _____
Street City Zip

Home Phone: (____) _____
Area Code

Does Child attend school? ☐ Yes ☐ No Name of school: _____

Father's/Guardian's Name: _____ Cell#: _____
Employer: _____ Work Phone: _____

Mother's/Guardian's Name: _____ Cell#: _____
Employer: _____ Work Phone: _____

Emergency Contact Person: _____ Phone: _____

☐ Medicaid ☐ PeachCare ☐ WellCare ☐ Amerigroup ☐ PeachState

Member Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

☐ I have received the Notice of Health Information Practices from the County Board of Health.
☐ I prefer to limit the disclosure of my health information
Signature: _____ Date: _____
If signed by someone other than the patient, please state relationship to patient: _____

★ Patients under 18 years of age must have the medical history and consent signed in ink by a parent or legal guardian before treatment begins.

PLEASE COMPLETE AND SIGN BACK OF FORM

Elegibilidad Dental Y Historial Medico

 **Bienvenidos!** Medical Alert: _____
Patient No.: _____

Escriba en tinta

Es nuestro placer darle la bienvenida a salud publica de Georgia. Tome unos minutos para llenar esta forma. Si tiene alguna pregunta con gusto le ayudaremos. Será un placer servirle en su salud dental.

Paciente: _____ Fecha de nacimiento: ____/____/____
Apellido Nombre Inicial

Edad: _____ Sexo: _____ Raza: _____

Direccion: _____ Condado: _____
Calle CiudadCodigo Postal

Telefono: (____) _____

El paciente esta en la escuela? ☐ Si ☐ No Nombre de escuela: _____

Nombre de padre/guardian: _____ Cell#: _____
Empleador: _____ Telefono de trabajo: _____

Nombre de madre/guardian: _____ Cell#: _____
Empleador: _____ Telefono de trabajo: _____

Persona en caso de emergencia: _____ Telefono: _____

☐ Medicaid ☐ PeachCare ☐ WellCare ☐ Amerigroup ☐ PeachState

Numero de Miembro:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

He recibido el aviso de practicas de informacion medica de salud publica de el condado de Gwinnett.
Prefiero limitar la divulgacion de mi informacion medica.
Firma: _____ Fecha: _____
Si la persona que firma no es el paciente, por favor declare la relacion con el paciente: _____

★ Pacientes menores de 18 años de edad necesitan tener el consentimiento y el historial medico firmado por madre/padre o guardian legal.

POR FAVOR FIRME Y RESPONDA LAS PREGUNTAS AL OTRO LADO

#2 Annual Consent and Authorization

Norcross Health Center/Children's Dental Clinic

5030 Georgia Belle Court Suite 2071

Norcross, GA 30093

770-638-5758

Annual Consent and Authorization

Patient name: _____ DOB: _____

Consent for Treatment:

I consent to the general dental treatment for myself/minor child which in the judgment of the dentist is necessary for oral health. This treatment may include but is not limited to the following: restoration of teeth, extraction of teeth, x-rays, administration of drug/local anesthetics, root canals, periodontal treatment, prosthetics, oral surgery, and other specialty treatment deemed necessary. I approve the release of my records to my insurance/Medicaid or other dentists as deemed necessary by the dentist. I authorize you to verify employment, financial, or medical history, and other related matters as may be necessary to determine eligibility. I authorize the dentist to file claims and receive reimbursement directly from my insurance/Medicaid. I understand that this request for dental treatment is valid for as many years as my child is eligible, by the program policy, for this service. This permission can be revoked only by written notification to the dental program administrator.

Consent to obtain Medical Records:

I hereby authorize Norcross Health Center/Children's Dental Clinic, to obtain medical records from any other physician/dentist or medical facility necessary in the course of my treatment.

Consent to Release Medical Information & or Records to a Parent, Family Member or Significant other:

I hereby authorize Norcross Health Center/Children's Dental Clinic, to release any information contained in my medical record to the person or persons listed:

1) _____ 2) _____ 3) _____

*If you do not authorize information to be released to anyone check this statement.

_____ I do not authorize any information to be released to anyone other than myself.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.

Signature _____ Date: _____

Parent/Guardian

Norcross Health Center/Children's Dental Clinic

5030 Georgia Belle Court Suite 2071

Norcross, GA 30093

770-638-5758

Consentimiento Y Autorizacion

Nombre de paciente: _____ Fecha que Nacio _____

Consentimiento para tratamiento:

Doy consentimiento a tratamiento dental general que sea necesario para mi hijo/a menor al cual a juicio de el dentista es mejor para mantener la salud dental. Este tratamiento incluye pero no está limitado restauracion dental, extraccion de dientes, rayos-x, administracion de medicamentos/anestesia local, root canal, tratamientos periodontales, protesticos, cirugia oral y otros tratamientos segun sean necesarios. Apruebo que mi informacion sea usada para el reclamo de aseguranza y para otros dentistas si el dentista lo cree necesario. Autorizo que se investigue mi estado financiero, mi historial médico, mi empleo y cualquier asunto necesario para determinar elegibilidad. Autorizo al dentista a enviar reclamos de seguro y recibir reembolso por servicios ofrecidos. Yo entiendo que esta peticion para recibir servicios dentales es válido mientras el paciente sea elegible al programa dental segun las polizas de el programa. Este permiso solo puede ser revocado por una notificacion escrita al Administrador del programa dental del departamento de salud de su condado.

Consentimiento para obtener historial medico:

Yo autorizo a Norcross Health Center/Children's Dental Clinic, obtener historiales medicos de cualquier medico/dentista o centro medico necesario por el transcurso de tratamiento.

Yo autorizo a Norcross Health Center/Children's Dental Clinic, liberar cualquier informacion contenida en mi expediente medico a la persona o personas siguientes:

1. _____ 2. _____ 3. _____

**Si usted no autoriza que su informacion medica sea liberada o compartida con nadie marque la siguiente declaracion.*

_____ Yo no autorizo que mi informacion sea liberada o compartida con nadie aparte de mi.

Yo reconozco haber leído consentimiento para tratamiento y consentimiento para obtener historial medico y reconozco que he sido informado/a de mis derechos a privacidad.

Firma _____ Fecha _____

Padres/Guardian Legal

#3 Dental Clinic Policies

Children's Dental Clinic
Norcross Health Center
5030 Georgia Belle Court
Norcross, Ga. 30093
770-638-5708

Dental Clinic Policies

Dear Parent,

It is expensive to provide dental treatment. Your County Board of Health will provide the funds for your county dental program only if patients will keep their appointments.

Always arrive at least 15 minutes early for your appointment time. All appointments are scheduled by time. If you are late the patient will not be seen and a new appointment will be given. If you break your appointment, your child will not be rescheduled in this clinic.

We will reschedule your child if we are given a 24 hour notice, or in case of illness, no later than 8:00 am on the day of your appointment. Call (770)638-5708 to notify us.

Always bring your Medicaid or Peachcare card to each visit. Cash or Credit Cards are accepted for patients who do not have Medicaid or Peachcare. The Health Department does not accept checks as form of payment.

I have read the policies listed above for patients participating in the dental program. I understand that my child's space in the dental clinic will be given to someone else if, I do not follow the above policies.

Parent/ Legal Guardian signature: _____

Date: _____

Children's Dental Clinic
Norcross Health Center
5030 Georgia Belle Court
Norcross, Ga. 30093
770-638-5708

Reglas De La Clinica Dental

Estimados Padres,

Es costoso proporcionar tratamiento dental. El Departamento de salud de su condado proporcionara los fondos para el programa dental, solamente si los pacientes mantienen sus citas.

Siempre llegue por lo menos 15 minutos antes de la hora de su cita. Si usted llega tarde el paciente no sera visto y haremos una nueva cita para el paciente. Si usted no mantiene su cita, no podremos darle otra cita a su nino/a en esta clinica.

Le daremos otra cita a su nino/a solamente si usted nos notifica con 24 horas de anticipacion o en caso de enfermedad, no mas tarde de las 8:00am el dia de la cita. Llame al (770)638-5708 para notificarnos.

Siempre traiga su tarjeta de Medicaid o Peachcare a cada visita. Efectivo o tarjetas de credito son aceptados para pacientes, que no tienen Medicaid o Peachcare. El departamento de salud no acepta cheques como forma de pago.

Yo he leído las polizas para los pacientes de el programa dental. Entiendo que el espacio de mi hijo/a sera dado a otro paciente si no cumplo las polizas.

Firma Del Padre/Guardian Legal : _____

Fecha: _____

We are here to help!



Hope Boyd
Parent Instructional Coordinator
hope.boyd@gcpsk12.org



Lynn Aristizabal
Parent Liaison
lynn.aristizabal@gcpsk12.org
Tel. 770-925-2100
Direct: 678-245-3922