

Cornerstone Care Mobile Dental Program

- This is an opt-in program. If you do not want services provided, please return the blank form.
- Signature is required. Signed consent includes initial visit and 6-month checkups when appropriate.
- Treatment is limited to exams, cleanings, fluoride, x-rays, sealants, and referral when necessary.
- Please send a photocopy of your insurance card for verification of coverage and eligibility.

Health and General Information— PLEASE PRINT CLEARLY IN INK & COMPLETE ALL SECTIONS **FRONT & BACK**

Child's Legal Name: _____ Child's Date of Birth: _____

Home Address: _____
 Street City Zip Code

Child's Social Security Number: _____ - _____ - _____ Birth Gender: M F (Circle one)

Race: ☐ White ☐ African American ☐ Asian ☐ Bi-Racial ☐ Native Hawaiian ☐ Pacific Islander ☐ American Indian

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

School: _____ Teacher: _____ Grade: _____

Parent/Guardian Name: _____ Phone Number: _____

Relationship to Child: _____

Parent/Guardian email address: _____ Parent/Guardian's Date of Birth: _____

***IMPORTANT:** List all medical conditions, medications, & allergies. Attach another page if more space is needed.

- ☐ Medical Conditions: _____
☐ Medications: _____
☐ Allergies: _____
☐ Dental Issues: _____

***Emergency Contact**

Contact Name: _____

Phone Number: _____

Relationship: _____

Primary Care Physician: _____

Primary Dental Provider: _____

*I would like more information on health insurance for my child: **Yes or No**

I give my permission for my child's photo to be taken for promotional use: **Yes or No

***Insurance Information**

I have medical insurance for my child: **Yes or No

What is the name of your child's primary medical insurance company? _____

ID Number: _____

Date of child's last dental visit: _____

I would like my child to be a member of the kid's club:

Yes or No

Name of Dental Insurance: _____

ID Number: _____

Group Number: _____

Name that appears on dental insurance card: _____

Insured Parent's Date of Birth: _____ Address: _____

Social Security number of the parent on the dental insurance card: _____ - _____ - _____

Telephone number shown on dental insurance card: _____

Insured parent/guardian employer name: _____ Relationship to child: _____

I give permission for my child to participate in the Cornerstone Care dental program during the current school term. I understand that my child will receive a dental exam, cleaning, fluoride, x-rays, and sealants if recommended by the dentist.

X: _____

Signature of Parent/Guardian

Date

Please Fill Out Back Side



HOUSEHOLD INCOME INFORMATION			
How many live in your household, including yourself?	The Appropriate Income Box	Yearly Income Between	
		0	15060
		15061	20440
		20441	25820
		25821	31200
		31201	36580
		36581	41960
		41961	47340
		47341	52720

Name of Patient – please print.

CORNERSTONE CARE

Acknowledgement of Receipt of Notice of Privacy Practices

Cornerstone Care has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement. We reserve the right to change out Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to Contact our Privacy Officer:

Mail: Cornerstone Care, Attention: Privacy Officer, 7 Glassworks Road, Greensboro, PA 15338

Telephone: (724) 943-3308 Fax: (724) 943-3310

Acknowledgement of Receipt:

I acknowledge that I have received that Notice of Privacy Practices for Cornerstone Care.

X

Signature of Parent/Guardian

Date

Consent to Disclosure of Personal Health Information to your child's School District

AND

Consent to Disclosure of Personal Health Information to Cornerstone Care

I, _____, give my permission to the staff of Cornerstone Care to release.
(Parent/Guardian name)

information regarding my child's medical and dental care, including my medical or dental condition, test results, appointment dates/times to the child's School/School District **AND** I give my permission to the staff of the School/School District to release information regarding my child's medical and dental care, including my medical or dental condition, test results, appointment dates/times to Cornerstone Care.

X

Signature of Parent/Guardian

Date

Good Faith Efforts to Obtain Acknowledgement of Receipt

I provided the above-named patient/parent/guardian with the Notice of Privacy Practices.

Describe how notice was provided:

X Copy of Privacy Notice enclosed in Cornerstone Care Mobile Dental Program Parent Consent Sheet

Describe efforts to obtain signature on acknowledgement of notice form:

☐ Parent/Guardian was asked to sign form and refused, returned form unsigned.

Cornerstone Care Mobile Unit Outreach Specialist

Date

Questions or Concerns

Contact: Cornerstone Care Outreach Department

Telephone: (267) 799-1916 x 1441