



Dental Services are Coming to Your Student's School

**No need for you to miss work or for your student to miss school.
Services provided on site during the school day.**

Services provided:

Screenings

Dental Health Education

Telehealth Exams by a Dentist

Cleanings

X-Rays

Intra Oral Photos

Fluoride Treatments

Sealants

Referral Services

We visit the school for a limited amount of time based on student enrollment. Please be sure to return your student's enrollment form promptly in order for your student to be seen.

Our Patient Bill of Rights & Privacy Notice can be found at: <https://mosaichealth.org/forms-and-documents>. A hard copy will be provided if requested.

Questions please call: (585) 243-7847

Completion of Dental Enrollment Form
is Required Each School Year

Participation

☐ **YES**, I give permission for my student to participate in the school based dental program.

Please go to the Student Information Section and complete the entire form.

☐ **NO**, I do not give permission for my student to participate in the school based dental program.

Please fill in student's name, school, teacher and sign and date below.

Student's Name: _____

School: _____ Teacher/Homeroom: _____

Printed Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Relationship to Student

Today's Date

Student Information

School: _____ Teacher/Homeroom: _____ Grade: _____

Last Name: _____ First Name: _____ M/I: _____ Suffix: _____

Date of Birth: _____ Sex at Birth: ☐ Male ☐ Female

Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Primary Spoken Language: _____ Interpreter Needed? ☐ Yes ☐ No

Parent/Legal Guardian Information

Last Name: _____ First Name: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Date of Birth: _____

Relationship to Student: ☐ Father ☐ Mother ☐ Legal Guardian (*please provide a copy of court order*)

Last Name: _____ First Name: _____

Date of Birth: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ WorkRelationship to Student: ☐ Father ☐ Mother ☐ Legal Guardian (*please provide a copy of court order*)**Responsible Party**☐ Same as above (*no need to complete the rest of this box*)

Last Name: _____ First Name: _____

Date of Birth: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ WorkRelationship to Student: ☐ Father ☐ Mother ☐ Legal Guardian

Street Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Information☐ Same as above (*no need to complete the rest of this box*)

Last Name: _____ First Name: _____

Date of Birth: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ WorkRelationship to Student: ☐ Father ☐ Mother ☐ Step-Parent ☐ Legal Guardian ☐ Other: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mosaic Health receives federal grant funding from the Health Resources and Services Administration (HRSA) to help us cover the costs of caring for your student. To receive these funds, HRSA needs information about the people we care for as a whole. We ask for information about your student's age, race, ethnic background, household size and income. This also helps us to understand your student's unique healthcare needs so that we can provide your student with the best care possible. We keep all your individual information confidential.

Student's Race (Mark all that apply):

- ☐ Choose not to disclose
- ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Asian (other)
- ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan
- ☐ Black/African American ☐ American Indian/Alaska Native ☐ White/Caucasian

Student's Ethnicity:

- ☐ Choose not to disclose
- ☐ Mexican ☐ Chicana/Chicano
- ☐ Mexican American ☐ Hispanic, Latino, or Spanish Origin
- ☐ Puerto Rican ☐ Not Hispanic, Latino, or Spanish Origin
- ☐ Cuban ☐ Other Hispanic, Latino, or Spanish Origin: _____

Household Information: Annual Household Income Please check a box

- | | | |
|---|--|--|
| ☐ Less than \$11,000 | ☐ \$30,001 – 35,000 | ☐ \$55,001 – 60,000 |
| ☐ \$11,001 – 15,000 | ☐ \$35,001 – 40,000 | ☐ \$60,001 – 65,000 |
| ☐ \$15,001 – 20,000 | ☐ \$40,001 – 45,000 | ☐ \$65,001 – 70,000 |
| ☐ \$20,001 – 25,000 | ☐ \$45,001 – 50,000 | ☐ \$70,001 – 75,000 |
| ☐ \$25,001 – 30,000 | ☐ \$50,001 – 55,000 | ☐ Greater than \$75,000 |

Household Size: _____

(Number of people in household this income supports)

Insurance Coverage

☐ Student has NO dental coverage

☐ Student has Medicaid/Medicaid Managed Care Plan

MEDICAID # _____
(2 letters, 5 #'S, 1 letter-ex. AB12345C)

Student's DENTAL Insurance Information, if other than Medicaid:

Subscriber Name (Name on Insurance Card): _____

Subscriber DOB: _____

Insurance Company: _____ Address: _____ Phone: _____

Subscriber ID#: _____ Group #: _____

Student's MEDICAL Insurance Information, if other than Medicaid:

Subscriber Name (Name on Insurance Card): _____

Subscriber DOB: _____

Insurance Company _____ Address: _____ Phone: _____

Subscriber ID#: _____ Group #: _____

Pharmacy Information

Student's Pharmacy Name: _____

Address/Location: _____

Phone Number: _____

Dental/Medical History

Dentist:

☐ Has **NEVER** seen a dentist

☐ **CURRENT** Dentist (*seen within the last 2 years*)

Dentist name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____

(The above dentist will be notified of dental services/outcomes provider through the dental program)

Medical Provider (Doctor, Nurse Practitioner, or Physician Assistant):

☐ Does **NOT** have a Medical Provider

☐ **Has** a Medical Provider

Name of Provider: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____

Does your student currently have or has previously had any of the following medical conditions?

(Please check all that apply)

☐ ADHD	☐ Autism	☐ Heart Condition	☐ Pregnancy
☐ Allergy to latex	☐ Blood Disorder	☐ High Blood Pressure	(Due Date: _____)
☐ Anemia	☐ Depression	☐ Liver Disease	☐ Seizures
☐ Anxiety	☐ Diabetes	☐ Low Blood Pressure	☐ Tuberculosis (TB)
☐ Artificial Joints	☐ Cancer	☐ Kidney Disease	☐ Other: _____
☐ Asthma	☐ Epilepsy	☐ ODD	_____

If **YES** to any of the above medical conditions, please explain: _____

Does your student **take any medications** daily? ☐ YES ☐ NO

Please list medications: _____

Does your student **have any allergies**? ☐ YES ☐ NO

Please list allergies: _____

Has your student had **any major surgeries**? ☐ YES ☐ NO

Please list types and dates: _____

Has your student had any **overnight hospitalizations** in the **past 3 years**? ☐ YES ☐ NO

Please list reason and dates: _____

Do you have any concerns regarding your **student's dental health**? ☐ YES ☐ NO

Please explain: _____

Consent:

In order to treat the student, **you must sign and date below** indicating you have read and agree to the following information...

I authorize my student to receive services provided by the staff of Mosaic Health. Services may include: a **dental screening, telehealth dental exam, intra oral photos, x-rays, dental cleaning with fluoride application and dental sealants.**

Authorization for Treatment:

I, the undersigned, the parent or legal guardian of the above-named student, hereby authorizes the dental staff of Mosaic Health to provide dental care as indicated to my student in their school. ***It is the parent/guardian(s) responsibility to inform the dental provider of any significant changes in their student's medical information. If you need to update your student's information or if you would like to be present at your student's appointment please call (585) 243-7847.***

Financial Responsibility/Assignment of Benefits:

I authorize Mosaic Health, Inc. to apply for benefits on my/my student's behalf to my insurance carrier and request my insurance company pay directly to Mosaic Health, Inc. insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify Mosaic Health of any changes. ***If your student has had a dental cleaning within the past 6 months and you have used your insurance, they are not eligible for insurance reimbursement at this time.*** If your insurance covers partial payment or denies services, you may be billed for services. **No student will be denied services due to inability to pay, please call for assistance.**

Service/Fees:

Dental Cleaning (Ages 0-12)- \$79.00
Dental Cleaning (Ages 13+)- \$114.00
Sealants per tooth- \$65.00
Fluoride Treatment- \$61.00

Dental X-rays: 2 BWX- \$59.00, 4 BWX- \$83.00
PA- \$36.00, Each Additional- \$33.00
Exam: New Patient- \$102.00, Established Patient- \$58.00

Release of Information:

If my student's health history indicates health problems which may affect their dental treatment or if proof of legal guardianship is needed, I consent to having my student's medical doctor/dentist/school release my student's medical/dental/guardianship information to the Mosaic Health dental staff. If a dentist is noted above, I understand that any dental findings/treatment shall be forwarded to that provider. I also give consent for Mosaic Health to provide my student's school faculty and staff with requested information to coordinate follow-up care.

******Forms that do not have a parent/ legal guardian's signature will be returned******

Student's Name: _____

Date of Birth: _____

Printed Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Relationship to Student

Today's Date