



CONSENT FOR DENTAL SERVICE

The Heart That Smiles has arranged for dental services for eligible children. These services may include exam, cleaning, fluoride treatment, and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists, and assistants will come to your child's school with portable equipment at an **announced time during the school year. If you would like your child to participate please complete the below information and return it to your child's school.** This signed consent includes initial visit and 6-month follow-up if scheduled. This will also give permission for IDPH Quality Assurance Audits to be performed and providers to return to your school to recheck your child's sealants.

School Name	Classroom	Home Phone
Student Name	Date of Birth	Grade Gender
Home Address	Apartment #	Zip Code

Has your child had any history of, or conditions related to, any of the following:
 ___ Anemia ___ Chronic Sinusitis ___ Growth problems ___ Seizures ___ Asthma ___ Diabetes
 ___ Hearing ___ Thyroid ___ Bleeding disorders ___ Ear aches ___ Heart ___ Tobacco/ drug use
 ___ Cancer ___ Epilepsy ___ Latex allergy ___ Fainting ___ Cerebral Palsy ___ Pregnancy (teens)
 Other _____
 Is your child taking any prescription and/or over-the-counter medications at this time? Yes No
 If yes, please list: _____
 Does your child have any speech difficulties? Yes No
 Has your child ever suffered injuries to the mouth, head, or teeth? Yes No

Medicaid/ Illinois ALL KIDS: If your child is covered by ALL KIDS, please include ID number:

Name of private dental insurance: _____
 Insurance Telephone Number _____ - _____ Group Number _____
 Employer Name _____
 Name of Insured _____ Date of Birth of Insured _____
 Social Security Number of Insured Person _____

If No Dental Insurance Please Check Box Below

I have no dental insurance and I would like someone to contact me about how I can still receive these great services.

SIGNATURE: _____ **Date:** _____

By signing this form, you give permission to treat your child. Furthermore, you acknowledge that you have had a chance to review our privacy policy on the back of this form. Our privacy policy is also available on our website. Copies available upon request. A report card will go home with your child following the dental visit. If you do not receive a form please call us at number listed below.

Privacy Policy

Our Legal Duty □ The Heart That Smiles is required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

Uses and Disclosures of Health Information □ We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician/dentist, dental auxiliaries, and other healthcare providers providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performances, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or the possible victim of other crimes.

Patient Rights □ **Access:** You have the right to look at or get copies of your health information, with limited exceptions.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. **Breach Notification:** We will provide you with notification of a breach of unsecured PHI as required by law.

Questions and Concerns □ If you would like to request a copy or want additional information about our privacy policy or have questions, you may contact Adriana Rivera at 708-808-4950. For a complete copy of this notice please visit us on the web at www.heartsmiles.org.

We support your right to maintain the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Address to the U.S. Department of Health and Human Services is available upon request.