CORNERSTONE CARE MOBILE DENTAL

IS COMING TO YOUR SCHOOL DISTRICT

REGISTER YOUR CHILD NOW TO RECEIVE:

- A DENTAL EXAM
- DENTAL CLEANING

The Smile for Life school-based and mobile dental program receives funding and contributions from:

Highmark Foundation

Delta Dental

Washington Financial

United Way of Washington County

Greene County United Way

Greene County Memorial Hospital Foundation

Community Foundation of Greene County

Henry Schein Cares Foundation

PLEASE SIGN THE PARENT PERMISSION FORM:
PLEASE COMPLETE:

- ✓ ALL FORMS IN THE STUDENT PACKET
- ✓ EVERYTHING IN RED IS REQUIRED
- ✓ COMPLETE THE ENTIRE BLUE SECTION AND RETURN IN THE ENVELOPE PROVIDED
- ✓ RETURN WITHIN 10 DAYS

PARENT INFORMATION SHEET

Your child's teeth are important. Dental disease (for example cavities and gum disease) can threaten a child's health, well-being, self-esteem and achievement. Children with oral health problems can have difficulty eating, sleeping and paying attention in school. Diseases such as cavities and gum disease are not always apparent and are actually contagious.

The Cornerstone Care Mobile Dental Program is a mobile dental unit that is a fully equipped dental office on wheels. By participating in the Cornerstone Care program, your child can receive quality oral health services, including dental exam and/or dental cleanings and be eligible to participate in the Smile for Life Kid's Club.

Dentists and Hygienists providing services on the mobile unit are the same providers who staff Cornerstone Care Dental Centers in Greene, Washington and Fayette Counties.

The program operates in four phases. ***Written parental permission is required to participate in Phases 1 through 3. By signing the enclosed consent form you are giving permission for your child to participate in the school dental program for the current school term which includes participation in phases 1 through 4 shown below.***

- Phase 1: Dental Exams performed by a licensed Dentist. Dental report cards are provided to parents following the dental screening
- Phase 2: Dental Cleanings performed by a licensed Dentist or a licensed Dental Hygienist ***(For students who have not had a dental cleaning in the past 6 months)***
- Phase 3: Referral for any necessary follow-up treatment either to the child's family dentist or to a Cornerstone Care Dental Center. Parents will be contacted either by the school district or the Cornerstone Care project coordinator

Payment of fees:
Children with dental insurance: Your child's dental insurance will be billed

Uninsured children: Cornerstone Care staff will work with you to enroll your child in the Children's Health Insurance Program commonly called CHIP.

Self-pay children: For children who are uninsured that do not want to apply for CHIP coverage, Cornerstone Care will provide services under the existing sliding fee scale. ***Proof of household income is required.***

Waiver of fee: Families who demonstrate an inability to make any payment of fees may apply for a fee waiver. ***Proof of household income is required.*** **No child will be turned away for inability to pay.**

For more information contact:

- For mobile unit information contact our Mobile Unit Outreach Specialist at (724) 852-1001 ext. 304
- For appointment information or billing questions contact Outreach Billing Specialist at (724) 852-1001 ext. 303
- For dental services questions contact: Dr. Charles Connors, Dental Director at (724) 947-2251
- Child uninsured? Please contact our Help Line at (724) 825-4411.
- For outreach and mobile services program information contact Donna Simpson, Manager of Outreach and Mobile Services at (724) 852-1001 ext. 306

The Smile for Life Kid's Club is a program that provides incentives for completing your dental treatment plan. All children ages 1-17 are eligible to participate. Every three months a random drawing is held of children who have returned their dental completion forms. Yes, you can continue to see your current dentist and still be eligible. The Club currently has over 1,100 members. Visit our website at www.SmileForLifeOnline.com for more information.

Cornerstone Care Mobile Dental Program

Please complete entire blue form
Parents please sign and return to your child's teacher within ten days
All information in red is required for child to be seen

A dental program is being offered at your child's school. Students in Head Start through the 12th grade are eligible to participate. A dental exam and dental cleaning. I be completed and your child will be referred for follow-up with a dentist as needed. Your child may receive a fluoride treatment as well.

Please check : _____ **YES**, 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, dental cleaning, and may receive a fluoride treatment.
Date signed:_____/_____/_____

Name of Student: _____ Birthdate : ____/_____/_____

Child's Social Security Number: _____-_____-_____(*required for dental record)*

Home address: _____
Street address City Zip

Home Phone: (_____)_____-_____ Child's Age: _____ Gender: *(circle one):* Male Female

Race: ○ American Indian/Alaskan Native ○ Asian ○ Black/African American ○ White ○ Native Hawaiian ○ Other Pacific Islander

○ Other, please specify:_____ _____Ethnicity: ○ Hispanic/Latino ○ Not Hispanic or Latino

School: _____ Teacher: _____ Grade:_____

Parents Name *(please print)*:_____ (Parent's) Cell/Work: (____)_____-_____

Day time phone number where Parent can be reached: (_____) _____ - _____

Parent's email address:_____

Parent/Guardian Signature: _____Parent's Date of Birth:_____/_____/_____

Please circle your answer to the following questions:

1. I would like my child to be a member of the Kid's Club Yes No
2. Is your child currently under a physician's care? Yes No
3. Has your child ever had any allergic reactions? Yes No
   Please explain any 'yes' answers in box on right--->
4. Does your child have a dentist? Yes No
5. Is your child eligible for the free/reduced cost lunch program at school? Yes No
6. My child's most recent dental visit was within the last (circle one):
   6 months 12 months 3 years 5 years Has never seen a dentist
7. Do you know of any present dental problems? Yes No
   If so, please list: _____
8. Was there a time when your child needed dental care and was unable to receive dental services? Yes No
   If yes, please explain why: _____

Allergies and reactions:
_____
_____
_____

All students are eligible for this service <u>except</u> those who have been seen by their regular dentist in the past 6 months.
Insurance WILL NOT COVER the cost for this service if your child has been seen by his/her dentist in the past 6 months.

9. How do you pay for your child's dental care (circle all that apply): Self Medicaid Private dental insurance CHIP

Name of your child's regular dentist: _____ Date of last exam: _____

Dentist phone number: _____Name of Pediatrician:_____

Please complete all of the information on the front, inside and back of this form.

Please check at least one:

_____ I do not have dental insurance for my child at this time. Please contact me to help me obtain insurance for my child/family.

_____ I would like my child to receive these services, but I need more information about the sliding-fee scale as a payment option.

_____ I would like information about CHIP (Children's Health Insurance Program) or Medicaid

_____ I have dental insurance for my child. Complete information below.

Comments or questions:
_____

_____

For Health Insurance Assistance Call: (724) 825-4411

Insurance Information (please fill out completely): Please Print all Information

Parent/Child name that appears on the Dental Insurance Card: _____

Social Security number of the parent on the Dental Insurance Card:_____

Date of Birth of the parent listed on the dental insurance card _____/_____/_____

Name of Dental Insurance Company: _____

Group Number: _____

ID Number on Dental Insurance Card: _____

Address of Insurance Company: _____

_____

Telephone Number shown on the Dental Insurance Card_____

Insured Parent's Employer Name: _____

Relationship to Patient _____ _____

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR CHILD'S DENTAL INSURANCE CARD TO THIS FORM

If you have any questions, please feel free to contact Our Outreach Specialist Mobile Services at 724-852-1001 ext. 304 or email at mobiledental@cornerstonecare.com.

Revision 01.08.2015

MEDICAL HISTORY

Patient Name_____Today's Date_____

Pediatrician's Name_____Date of last visit_____

Have you had any serious illnesses or operations?_____

If yes, please describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No if yes, give approximate dates _____

Has your physician ever required you to take medication prior to a dental procedure? ☐ Yes ☐ No

If yes, Why?_____

Read carefully, check (√) if you have or have had any of the following:

	AIDS			Fainting			Respiratory Disease
	Anemia			Glaucoma			Rheumatic Fever
	Arthritis/Rheumatism			Headaches			Scarlet Fever
	Artificial Heart Valves			Heart Murmur			Shortness of Breath
	Artificial Joints			Heart Problems			Skin Rash
	Asthma			Hemophilia			Stroke
	Back Problems			Hepatitis			Swelling, Foot/Ankle
	Blood Disease			High Blood Pressure			Thyroid Problems
	Cancer			HIV Positive			Tobacco Habit
	Chemical Dependency			Jaw Pain			Tonsillitis
	Chemotherapy			Epilepsy			Psychiatric Care
	Circulatory Problems			Kidney Disease			Radiation Treatment
	Cortisone Treatments			Mitral Valve Prolapse			Tuberculosis
	Cough, Persistent			Nervous Problems			Ulcer
	Diabetes			Pacemaker			Other

Women Only

Are you pregnant? ☐ Yes ☐No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐No

ALLERGIES

	Aspirin			Latex			Penicillin or other Antibiotics
	Barbiturates, Sleeping Pills			Local Anesthetic			Sulfa Drugs
	Codeine or other Narcotics			Hay Fever/Seasonal			Iodine
	Other (list)						
	Food Allergies: Please List						

MEDICATIONS

Please list any medications that you are currently taking:

_____

_____

Pharmacy Name_____ Phone Number_____

Do you have any disease, condition, or problem not listed above that you think the dental professionals should know about? ☐ Yes ☐ No If yes, please explain_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature:_____

_____

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 our 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) 943-4929

Acknowledgement of Receipt:

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

X_____ _____

Signature of parent (or personal representative) Date

Personal Representative: _____ Relationship/Authority: _____

(Name of Personal Representative – Please Print)

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

(parent's/representative's name)

to release 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 District **AND** I give my permission to the staff of the 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 (or personal representative) Date

Personal Representative: _____ Relationship/Authority: _____

(Name of Personal Representative – Please Print)

Good Faith Efforts to Obtain Acknowledgement of Receipt

I provided the above named patient/personal representative with the Notice of Privacy Practices.

Describe how notice was provided:

X Copy of Privacy Notice enclosed in Cornerstone Care Mobile Dental Program Parent Information packet

Describe efforts to obtain signature on acknowledgement of notice form:

☐ Patient/personal representative was asked to sign form and refused, returned form unsigned

_____ _____

Cornerstone Care Mobile Unit Outreach Specialist Date

CORNERSTONE CARE, INC.

Notice of Privacy Practice
Summary

Our practice has a long-standing commitment to confidentiality and protecting the privacy of patient information, which includes any information related to your health, treatment or payment for your treatment that can identify you. Our privacy practices are in accordance with applicable federal and state laws.

New federal legislation requires that we have a "Notice of Privacy Practices". A copy of the notice for our practice is attached. This notice explains how we protect your privacy, as well as your legal rights regarding your medical information. This is a brief summary of the content of the "Notice of Privacy Practices." It is not a complete listing of how we use and share your health information.

We may use and disclose your information without your consent:

- To provide treatment to you
- To coordinate your care with other providers
- To conduct standard health care operations business functions
- To bill and receive payment for the services we provide to you, including billing your insurance company or other party responsible for your bills
- To comply with pertinent government agency reporting requirements
- To meet other special reporting requirements as described in the Notice

(Note that information related to behavioral health, drug and alcohol services and AIDS/ HIV are protected by additional state laws.)

We can share your health information with family and/or friends who you agree can have this information. You can give verbal permission for these disclosures.

All other use of your health information will be made only with your specific written permission, or authorization.

You have the following legal rights regarding your health information:

- Right to see your medical record
- Right to have a copy of your medical record (there may be a charge for this)
- Right to ask for a list of who has seen your health information for any reason other than treatment, payment or other health care operations
- Right to ask for more restrictions on the use of your health information. (We are not required to agree to your request.)
- Right to ask for special confidential communication from our practice. (We are not required to agree to unreasonable requests.)
- Right to ask for a change to be made to your medical record
- Right to a copy of our "Notice of Privacy Practices"
- Right to file a complaint if you feel your privacy was violated

If you have any questions, please contact our Privacy Officer at (724) 943-3308.

November 2008

CORNERSTONE CARE SERVICES

Primary Care Medicine
Family Practice
Gynecological (Women's Health)
Osteopathic Manipulation
Employment/School Physicals
Employment Drug/Alcohol Screening
Diagnostic and Laboratory Services
Diabetes Education
Cancer Screenings

Pediatric Medicine
Pediatric Care
School Physicals
Diagnostic and Laboratory Services

Psychiatric Medicine
Child, Adolescent, & Adult Psychiatry
Child, Adolescent, & Adult Individual Counseling
Couple & Family Counseling
Group Counseling
Neuropsychological Testing
Diagnostic and Laboratory Services

Chiropractic
Chiropractic Care
Massage Therapy

Podiatry
Podiatry

Dental
General Dentistry
Orthodontics
Dental Cleanings
Dentures/Prosthodontics
Dental Whitening
Diagnostic Services

Mobile Unit
Mobile Services

CORNERSTONE CARE LOCATIONS

Burgettstown, PA
Community Dental & Medical Plaza
1227 Smith Township State Road
Burgettstown, PA 15021

Greensboro, PA
7 Glassworks Road
Greensboro, PA 15338

Mt. Morris, PA
Primary Care Center of Mt. Morris
120 Locust Avenue Extension
Mt Morris, PA 15349

Rogersville, PA
140 Church Street - Suite 102
Rogersville, PA 15359

Uniontown, PA
140 North Beeson Avenue (Suites 300A & 401)
Uniontown, PA 15401

Washington, PA
Pediatric Associates of Washington
400 Jefferson Avenue
Washington, PA 15301

Waynesburg, PA
Central Greene Pediatrics
236 Elm Drive
Waynesburg, PA 15370

Waynesburg, PA
Dental, Psychiatry & Counseling Center
501 West High Street
Waynesburg, PA 15370

Mobile Unit
Mobile Services

SERVICES AVAILABLE BY LOCATION

Burgettstown, PA — 724-947-2255
Community Dental & Medical Plaza
Primary Care Medicine
Psychiatric Medicine
Chiropractic
Dental **(724-947-2251)**

Greensboro, PA — 724-943-3308
Primary Care Medicine
Psychiatric Medicine
Chiropractic
Podiatry
Dental

Mt. Morris, PA — 724-324-9001
Primary Care Center of Mt. Morris
Primary Care Medicine
Psychiatric Medicine
Dental

Rogersville, PA — 724-499-5188
Primary Care Medicine
Chiropractic
Podiatry

Uniontown, PA
Outreach Services **724-439-1628**
Dental **724-439-8170**

Washington, PA — 724-228-7400
Pediatric Associates of Washington
Pediatric Medicine

Waynesburg, PA — 724-627-0926
Central Greene Pediatrics
Pediatric Medicine

Waynesburg, PA
Dental, Outreach, Psychiatry & Counseling
Psychiatric Medicine **724- 627-4309**
Dental and Outreach **724-852-1001**