Grade_______ Room#________

DENTAL SERVICES IN SCHOOL

CHOMPERS! PORTABLE DENTAL PROGRAM

CREATING HEALTHY SMILES

828-7583

Dental Exams and X-Rays

Cleanings and Fluoride Treatments

Dental Sealants

Restorations (Fillings)

Oral Health Education

Referrals for Advanced Care

PLEASE MAKE SURE THE FORM IS COMPLETELY FILLED OUT FRONT TO BACK

INSURANCE WILL BE BILLED FOR SERVICES

NO OUT OF POCKET FEES OR COPAYS APPLY TO THIS PROGRAM

NO FEES WILL APPLY TO STUDENTS WITHOUT DENTAL INSURANCE

The CHOMPERS Dental Program's purpose is to provide dental services to students who ***DO NOT*** have a family dentist and link them to a permanent dental office. Parents wishing to have a child enrolled because of inability to return to the dental home should contact the Program Assistant to discuss enrollment options.
http://www.bakervictoryservices.org/chompers-school-based-dental

SPONSORING AGENCIES

CHOMPERS! DENTAL PROGRAM
BAKER VICTORY HEALTHCARE CENTER
716-828-7583

*******PLEASE RETURN COMPLETED FORMS TO THE NURSES OFFICE*******

If you already have a family dentist, please continue care with that provider

Child's Name: ___________________________ DOB: _____________________

________ My child has never seen a dentist

________ My child does ***NOT*** have a regular dentist at this time

________ My child has been to a dentist within the last 6 months

Dentist Name: __________________________ Phone:____________

Address: ____

Has your child seen the dentist in school before? YES / NO

Race/ethnicity (for tracking purposes only) check all that apply:

____White ____Black/African American _____American Indian/Alaska Native
____Asian ____ Hispanic _____Native Hawaiian/Pacific Islander

CONSENT TO PARTICIPATE

- I consent to my child receiving the following dental services: exams, x-rays, cleanings, fluoride, fillings, sealants
- I consent to my child receiving re-evaluation of the sealants placed during the school year within six to fifteen months of the initial placement
- I understand that if my child is in need of an extraction, I will be contacted by the dentist or dental assistant prior to the service being rendered
- I give permission for my child to have fillings with the use of local anesthesia, commonly called “novocaine.”
- I understand that this consent may stay in effect for one (1) school year while my child attends this school.
- It is the parent/guardian’s responsibility to inform the dental provider and/or the school nurse of any changes in their child’s medical information
- I understand that a copy of my child’s dental report may be given to the school nurse or designated site coordinator and that all information about my child will be kept confidential within the CHOMPERS Partnering Agencies.
- **If I have dental insurance, I authorize my insurance carrier to be billed for any services provided**.
- I have been given a copy of the Baker Victory Dental Center Notice of Privacy Practices and Bill of Rights.
- I understand that Baker Victory Dental Center may use my child’s health information for treatment, payment, health care operations, and program evaluation.
- I have read and understand the dental program and I consent to have my child participate in CHOMPERS dental program.

☐ **YES,** I give permission for my child to participate in the CHOMPERS Program

☐ **NO,** I do not give permission for my child to participate

____
Signature of Parent or Legal Representative

____
Printed Name of Parent or Legal Representative

____
Relationship to the Child

____
Today’s Date

CHOMPERS! DENTAL PROGRAM
BAKER VICTORY HEALTHCARE CENTER
716-828-7583

Child's Name:_________________________________ DOB:________________________ Male / Female

Address:__________________________________ City:__________________________ Zip Code:__________

Phone (H):______________ SS# _____-_____-______ School:____________ **Grade**________ **Room #:**_______

Parent Name: ____ Cell:_________________

Parent Email Address: ____ Work Phone:________________

Does Your Child Have Any Of The Following Medical Conditions?

AIDS/HIV	YES	NO	Asthma	YES	NO	Birth Defects	YES	NO
Bleeding Disorders	YES	NO	Congenital Heart Disease	YES	NO	Diabetes	YES	NO
Fainting Spells	YES	NO	Epilepsy/Seizures	YES	NO	Rheumatic Fever	YES	NO
Heart Murmur	YES	NO	Hearing Loss	YES	NO	Kidney Disease	YES	NO
Heart Disease	YES	NO	GI Problems	YES	NO	Tuberculosis	YES	NO
Hepatitis/Liver Disease	YES	NO	Immune Deficiency	YES	NO	Vision Problems	YES	NO
Venereal Disease	YES	NO	High Blood Pressure	YES	NO	Low Blood Pressure	YES	NO
Psychiatric Disorders/ ADHD	YES	NO	Artificial Joints	YES	NO	Pregnancy	YES	NO

Has your Child ever been hospitalized, had a serious injury, or had surgery? YES NO

What For / When? ____

Does your Child need to take pre-medication (antibiotics) before dental work is done? YES NO

Does your Child take any medication on a DAILY basis? (please circle): YES NO
Please List Daily Medications____

Does your Child have any allergies to the follow items? (please circle): YES NO
Latex Tree Nuts Seasonal Resins Foods Antibiotics Penicillin Other: ________________________

Does your Child Have Medical Insurance? YES NO Plan: ___________ Pharmacy Name & Number _______________

Required: INSURANCE INFORMATION- INSURANCE WILL BE BILLED FOR SERVICES

_______ **UNINSURED** (no dental coverage)

_______ **MEDICAID INSURANCE** **(required)** ID # _________________ SEQ #_______________
(2 letters, 5 #s, 1 letter-ex. AB12345C) (2 #s lower right of BENEFIT card-ex. 01)

_______ **PRIVATE DENTAL INSURANCE** ID #______________________ GROUP #_______________

PLAN NAME___________________________ INSURANCE PHONE# ___________________

POLICY HOLDER NAME_____________________________________ DOB_______________

EMPLOYER ____ SS# _______________

(Required) EMERGENCY CONTACT INFORMATION (other than parent listed above please)

Contact Person's Name:_________________________________ Relationship to Child:_______________________

Phone Number (Home)_____________________ (Cell)_________________________ (Work)_____________________

Please feel free to add any comments you would like about your child's previous dental treatment in the space below:

Thank you for choosing the CHOMPERS! Dental Program

Please tear off the following page which includes our Privacy Policy and Patient Bill of Rights

CHOMPERS! DENTAL PROGRAM
BAKER VICTORY HEALTHCARE CENTER
716-828-7583

Consent To Use and Disclose Protected Health Information For Treatment, Payment and Health Care Operations

Section A:

I authorize the use and disclosure of my Protected Health Information by the Agency listed below and by the Agency's staff and Business Associates for purposes of treatment, payment and health care operations.

Name of Agency Using and Disclosing the Information:
Baker Victory Services
Contact Telephone Number (716) 828-7583

Agency Address:
780 Ridge Road
Lackawanna, NY 14218

Section B. Important Information Regarding this Consent:

1. I understand New York laws require my consent before the Agency may use or disclose my Protected Health Information for treatment, payment or health care operations.

2. I understand that this information may be used or disclosed by the Agency to:

   - plan my care and treatment;
   - communicate among various health care professionals who are involved in my care or treatment;
   - obtain payment for care provided by the Agency or for the payment activities of another health care provider or entity;
   - provide information to my health insurance company or plan;
   - **obtain payment from my health insurance company or plan; and**
   - assess and review the quality of my care.

3. I understand that my signature on the consent is required in order for me to receive care from the Agency and that the Agency may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for treatment, payment and health care operations.

4. I understand that further information on the Agency's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in the Agency's Notice of Privacy Practices.

BAKER VICTORY SERVICES
Continuing Father Baker's Legacy of Caring

CHOMPERS! DENTAL PROGRAM
BAKER VICTORY HEALTHCARE CENTER
716-828-7583

PATIENT BILL OF RIGHTS

As a patient you are afforded the right to:

1. **Be treated with consideration, respect and dignity including privacy in treatment.**
2. **Receive service(s) without regard to age, race, color, sex, religion, marital status, ethnic or national origin or disability.**
3. **Be informed of the service available at the center.**
4. **Be informed of provisions for after-hours emergency coverage.**
5. **Obtain from your physician complete and current information concerning your diagnosis, treatment, and prognosis in terms you can be reasonably expected to understand. When it is not medically advisable to give you such information it shall be made available to an appropriate person in your behalf.**
6. **Receive from your physician information necessary to give informed consent prior to the start of any procedure or treatment or both and which, except for those emergency situations not requiring an informed consent, shall include as a minimum the specific procedure or treatment or both, the medically significant risks involved, and the probably duration or incapacitation, if any. You shall be advised of medically significant alternatives for care or treatment, if any.**
7. **Refuse treatment to the extent permitted by law and to be informed of the medical consequences of your action.**
8. **Privacy to the extent consistent with providing adequate medical care. This shall not preclude discrete discussion of your care or examination by appropriate health care personnel.**
9. **Privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third party payment.**
10. **Approve or refuse the release or disclosure of the contents of your medical record to any health care practitioner and/or health care facility except as required by law or third party payment contract.**
11. **Access your medical record pursuant to the provision of Section 18 of the Public Health Law and Subpart 50-3 of this title.**
12. **Review your medical record without charge, and obtain a copy of the medical record for which the center can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.**
13. **Be informed of any changes for services, eligibility for third party reimbursements and, when applicable, the availability of free or reduced cost.**
14. **A response by the Baker Victory Healthcare Center in a reasonable manner, to your request for services customarily rendered by the facility consistent with your treatment.**
15. **The identity, upon request, of other health care and educational institutions that the facility has authorized to participate in your treatment.**
16. **Refuse to participate in research and that human experimentation affection care or treatment shall be performed only with your consent.**
17. **Examine and receive an explanation of your bill, regardless of source of payment.**
18. **Know the rules and regulations that apply to your conduct as a patient.**
19. **Refer any complaints and/or questions with regard to your rights to the Administrative Director of the Baker Victory Healthcare Center. If you are not satisfied by the center's response you may complain to the NYS Department of Health's Office Systems Management at (716) 847-4307.**

CHOMPERS! DENTAL PROGRAM
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How Does A Sealant Help Prevent Decay?

- The sealant acts as a barrier, protecting the enamel from plaque and acids. Sealants protect these vulnerable areas by "sealing out" plaque and food.
- The key to preventing tooth decay and maintaining a healthy mouth are twice-daily brushing with fluoride toothpaste; cleaning between the teeth daily with floss, eating a balanced diet and limiting snacks; and visiting your dentist regularly.

Flossing and Brushing

1 Place the brush at a 45 degree angle to the tooth surface. The bristles should contact both the tooth and the gum line.

2 Move the brush in a small, circular, jiggling motion.

3 Use a small back and forth motion to clean the inside surfaces of the back teeth.

4 Tilt the brush vertically and use small up and down strokes to clean the inside surfaces of the front teeth.

5 Brush the biting surfaces, using a back and forth motion.

KEW PERIODONTICS

1 Take about 50 centimetres of floss and wind most of the floss around each middle finger.

2 Holding the floss tautly between your thumbs and index fingers, slide it gently between your teeth. Never snap the floss onto the gums.

3 Gently curve the floss around the base of one tooth. Use and up-and-down motion, making sure you go beneath the gum line. Gently curve the floss around the other tooth and use the same technique.

4 Be sure to also floss at the back surfaces of the last molars.

KEW PERIODONTICS

Maternity and Dental Care

- It is important for pregnant women to get their teeth cleaned, examined and have any needed dental work done before their baby is born
- Studies show that there may be an association between periodontal disease - a chronic infection of the gums - and premature birth (delivery before 37 weeks) and low-birth weight (baby weighing less than 2,500 grams)
- Improving oral health during pregnancy can also help prevent early cavities in their child.