

Delta Dental Mobile Program

Patient Information Form

A

Please fill out this form completely. If you have questions, please ask a Delta Dental staff member. Thank You!

Patient's Legal Name _____ Birth Date (mm/dd/yyyy) _____

Patient's Social Security Number _____ - _____ - _____

School Attending _____ Grade _____ Age _____ Sex (circle) M F

Ethnicity: (circle) *White* *Black or African American* *Asian* *American Indian* *Hispanic/Latino* *Other*

Home Address _____

Mailing Address _____ City _____ State _____ Zip _____

Phone Numbers: Home (____) _____ Work (____) _____

Cell (____) _____

Parent/Guardian Name _____

Emergency Contact: Person to contact in case of an emergency

Name _____ Relation to patient _____ Phone (____) _____

Income: Which of these best represents your annual household income? (circle one)

Less than \$10,000 *\$10,000-20,000* *\$20,000-30,000* *More than \$30,000*

Household Size: How many children less than 21 years of age live in your household? _____

Note: Dental visits should start at first tooth.

Dental History	Yes	No	
Is this the patient's first dental visit?			If no, how long has it been? (✓) ____ less than 13 months ____ less than 2 years ____ more than 2 years
Past or current dentist name _____			
Does the patient brush daily?			
Does the patient floss?			
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?			
Does the patient drink milk daily?			
Has dental pain caused you or your child to miss school and/or work in the last year?			If "yes", circle – school work both How many times?
Has the patient visited the ER/hospital for dental pain in the last year?			If "yes", how many times?

Medical History	Yes	No	Please Explain "yes" Answers
Patient's current physician _____			Date of last medical exam (mm/yy) _____
Does the patient have a current medical condition?			
Is the patient taking any medications?			
Has the patient ever been hospitalized or had surgery?			
Does the patient have any allergies?			
Is the patient current on immunizations?			
Does the patient have any special needs that would require special arrangements for dental care? i.e. autism			
Is patient pregnant?			

Reason for Visit: Check any that apply (✓)

- ☐ First examination ☐ Couldn't afford dental care ☐ Couldn't get appointment anywhere else
☐ Toothache/mouth pain/face swelling ☐ Other (specify) _____

Has the patient had a history of or had difficulty with the following? Check any that apply (✓)

- | | | | |
|---|---|---|--|
| ☐ Latex allergy | ☐ Asthma | ☐ Diabetes | ☐ Liver disease |
| ☐ AIDS / HIV | ☐ Birth defects | ☐ Fainting | ☐ Mono |
| ☐ Epilepsy/ seizures | ☐ Cancer | ☐ Heart problems | ☐ Rheumatic fever |
| ☐ Excessive bleeding | ☐ Cerebral Palsy | ☐ Hepatitis | ☐ Tuberculosis |
| ☐ Anemia | ☐ Convulsions | ☐ Kidney disease | ☐ Other _____ |

Please explain "yes" answers: _____

Behavioral Issues	Yes	No
Is the patient using tobacco products (cigarettes, chewing tobacco)?		
Does anyone smoke in the household?		
Is the patient using alcohol and/or drugs?		

Insurance: Please circle any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided. **MUST PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD IF APPLICABLE.**

Medicaid/ SCHIP Private DENTAL Insurance (please provide copy of card) IHS None
 Medicaid Number/ Policy Number _____ Reservation (IHS) _____

Dental Ins. Name: _____ policy # _____ group # _____

Dental Ins. Address: _____ Ins. Phone # _____

Employer Name: _____

B**Treatment Consent and Agreement**

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print child's name)
 give my consent for the dental services I have authorized below. I understand there may be risks involved with dental treatment. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular dental exams by a dentist. Each item needs to be answered in order to receive dental care.

Yes	No	
		Preventive Services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.
		Dentist Exam (including dental x-rays)
		Restorative Services: fillings, stainless steel crowns, pulpotomy. Anesthesia is used for these procedures.
		Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Anesthesia is used for these procedures.
		I have received and/or read a copy of the Delta Dental's HIPAA Notice of Privacy Practices
		I consent to share my or my child's health care records with other health care providers or agencies as needed.
		I consent to the use of pictures, video or audio recordings of myself or my child for program promotion.

Parent/Legal Guardian signature _____ Date _____

Confidentiality of your health care information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is required by law to inform you of how Delta Dental protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as individually identifiable information regarding a patient's health care history, mental or physical condition or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We follow the privacy practices described in this notice and federal and state privacy requirements that apply to our administration of your benefits. Delta Dental reserves the right to change our privacy practice effective for all PHI maintained. We will update this notice if there are material changes and redistribute it to you within 60 days of the change to our practices. We will also promptly post a revised notice on our website. A copy may be requested anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program and will be informed on how to obtain a copy at least every three years.

Permitted uses and disclosures of your PHI**Uses and disclosures of your PHI for treatment, payment or health care operations**

Your explicit authorization is not required to disclose information about yourself, or for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or plan sponsor to administer your benefits. As permitted by law, we may also disclose PHI to third-party affiliates that perform services for Delta Dental to administer your benefits. As permitted by law, we may disclose PHI to third-party affiliates that perform services for Delta Dental to administer your benefits, and who have signed a contract agreeing to protect the confidentiality of your PHI, and have implemented privacy policies and procedures that comply with applicable federal and state law.

Some examples of disclosure and use for treatment, payment or operations include: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Some other examples are:

- Uses and/or disclosures of PHI in facilitating treatment. *For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment. *For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations. *For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

Other permitted uses and disclosures without an authorization

We are permitted to disclose your PHI upon your request or to your authorized personal representative (with certain exceptions) when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action; or a subpoena in an arbitration;
- Investigative subpoena of a government board, commission, or agency;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Some other examples include: to notify or assist in notifying a family member, another person, or a personal representative of your condition; to assist in disaster relief efforts; to report victims of abuse, neglect or domestic violence to appropriate authorities; for organ donation purposes; to avert a serious threat to health or safety; for specialized government functions such as military and veterans activities; for workers' compensation purposes; and, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting, provided it does not contain genetic information. Information can also be de-identified or summarized so it cannot be traced to you and, in selected instances, for research purposes with the proper oversight.

Disclosures Delta Dental makes with your authorization

Delta Dental will not use or disclose your PHI without your prior written authorization unless permitted by law. You can later revoke that authorization, in writing, to stop the future use and disclosure. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

Your rights regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI.

You may access your PHI by contacting Delta Dental at the address at the bottom of this notice. You must include (1) your name, address, telephone number and identification number, and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or x-rays, is returned by Delta Dental to the dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact Delta Dental as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI.

You have the right to ask that we limit how we use and disclose your PHI, however, you may not restrict our legal or permitted uses and disclosures of PHI. While we will consider your request, we are not legally required to accept those requests that we cannot reasonably implement or comply with during an emergency. If we accept your request, we will put our understanding in writing.

You have the right to correct or update your PHI.

You may request to make an amendment of PHI we maintain about you. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact our privacy officer as noted at the end of this notice if you have questions about amending your PHI.

You have the right to opt-out of Delta Dental using your PHI for fundraising and marketing.

Delta Dental does not use your PHI for either marketing or fundraising purposes. If we change our practice, we must give you the opportunity to opt-out. We may send you newsletters or information regarding your dental program.

You have the right to request or receive confidential communications from us by alternative means or at a different address.

Alternate or confidential communication is available if disclosure of your PHI to the address on file could endanger you. You may be required to provide us with a statement of possible danger, as well as specify a different address or another method of contact. Please make this request in writing to the address noted at the end of this notice.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

You have a right to an accounting of disclosures with some restrictions. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons, certain law enforcement purposes or disclosures made as part of a limited data set. Please contact us at the number at the end of this notice if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by e-mail.

A copy of this notice is posted on the Delta Dental website. You may also request an email copy or paper copy of this notice by calling our Customer Service number listed at the bottom of this notice.

You have the right to be notified following a breach of unsecured protected health information.

Delta Dental will notify you in writing, at the address on file, if we discover we compromised the privacy of your PHI.

Complaints

You may file a complaint to Delta Dental and/or to the U. S. Secretary of Health and Human Services if you believe Delta Dental has violated your privacy rights. Complaints to Delta Dental may be filed by notifying the contact below. We will not retaliate against you for filing a complaint. You may contact Delta Dental at 877-841-1478, or you may write to: Delta Dental, P.O. Box 1157, Pierre, SD 57501 for further information about the complaint process or any of the information contained in this notice.

Language Assistance

Can you read this document? If not, we can have somebody help you read it. For help, please call Delta Dental at 877-841-1478 and we will connect you with a translator.

Summary of Changes to this notice (effective September 23, 2013):

- Updated Delta Dental's duty to notify affected individuals if a breach of their unsecured PHI occurs
- Clarified that Delta Dental does not and will not sell your information without your express written authorization
- Clarified several instances where the law requires individual authorization to use and disclose information (e.g., fundraising and marketing as noted above)