

FREE DENTAL CARE!

Give Kids a Smile!

March 8 & 9

George O Barr



Eligible students get a free
DVD rental & Cheezybread

family
video

marco's
Pizza



FREE dental exam, cleaning, & oral
hygiene education

\$90
Value!



FREE fluoride treatments

\$30
Value!



FREE dental sealants

\$160
Value!



FREE toothbrush, toothpaste, & floss!

Complete the attached form & return it by FEB 22!

Keeping *children* safe, strengthening *families*, and building healthy *communities* since 1899



Give Kids A Smile Dental Program

Dear Parent or Guardian,

Bethany for Children & Families is offering free dental care through the Give Kids a Smile Dental Program for children who cannot afford to get dental care on their own. To provide this care, our dental bus will come to your child's school. All service individuals are licensed dental professionals.

Your child *may qualify* for this program *if* he/she:

- has never been to the dentist;
- has not been to the dentist in the six (6) months;
- receives Medicaid/ the medical card; Hawk-I; and/or
- Is **not** covered under a private dental insurance. (**PLEASE NOTE**—Due to financial constraints, uninsured patients are limited to 1 visit per lifetime with GKAS.)

On the day the bus comes to your school, your child will receive:

- oral health education;
- a dental exam;
- teeth cleaning;
- fluoride treatment, and
- possibly sealants.

If follow-up treatment is needed for your child, a Bethany for Children & Families staff member can help schedule an appointment with a dentist to provide the follow-up care.

There is NO CHARGE for services on the bus.

(If your child is enrolled in the state Medicaid system, Medicaid will be billed for services provided on the bus and for any follow-up services that need to be done.)

If you want to have your child participate in this program, please complete the form attached and return it to school.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeff Cornelius".

Jeff Cornelius

Questions?

Call: 309-736-6627

Permission Form for Give Kids a Smile Dental Program

Please PRINT in ink within the boxes

Child's first name	Child's last name	Child's birth date	Child's gender M <input type="checkbox"/> F <input type="checkbox"/>
Parent/guardian's first name(s)		Parent/guardian last name(s)	

Address	City	State	Zip
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First Phone#:	What race do you consider your child? Black <input type="checkbox"/> White <input type="checkbox"/> Multiracial <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian Native <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> _____ What heritage do you consider you child?: Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/>
Second Phone #:	
Email Address:	
Emergency Contact: _____	
Contact's Phone #: _____	

Child's Medicaid Recipient ID Number (9 digit number on back of Medi-Plan card)

Child's school	Teacher	Grade
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Is your child eligible?

What type of dental insurance does your child have?

1. **Dental** insurance: United Concordia Delta Dental Metlife Other _____
2. Medicaid (Medical Card, Title 19), Meridian, Illini Care, or Health Alliance
3. No dental insurance (**PLEASE NOTE** - Uninsured patients may be limited to 1 visit per lifetime depending on program funding.)

Where does your child go for dental care?

1. When was your child's last dental visit? _____
2. Where does your child go for dental care? Name of dentist/office: _____
3. Has your child been seen on the GKAS dental bus before? Yes or No

For office use only:

PLEASE SEE OTHER SIDE

Important Health History:

Your child's Medical History [Complete both columns]

Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Ailment or Angina	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur, Heart Defect	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Artificial Heart Valve	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	High/Low blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Leukemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pace Maker	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Artificial Joints	Yes <input type="checkbox"/> No <input type="checkbox"/>
Radiation Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatoid Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Osteoporosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Chronic Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis and/or Liver Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stomach Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>
HIV/AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizure Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Downs Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/>	Brain Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>
Autism	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cerebral Palsy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting/Dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pregnancy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hearing Difficulties	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fever Blisters and/or Cold Sores	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic Earaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>
ADHD/ADD	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mental/Physical Disabilities	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma Yes <input type="checkbox"/> No <input type="checkbox"/> Carries Inhaler?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Triggers for Asthma:	
Any Surgeries?	Yes <input type="checkbox"/> No <input type="checkbox"/>	List Surgeries/Dates:	
Caffeine Use?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If so, how much/how often?	
Allergies:		Does your child need an antibiotic before a dental procedure? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Latex	Yes <input type="checkbox"/> No <input type="checkbox"/>	List Medications Taken:	
Nut	Yes <input type="checkbox"/> No <input type="checkbox"/>	Medication	Dose
Food	Yes <input type="checkbox"/> No <input type="checkbox"/>		How often?
Anesthetics	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Metal	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Others	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Please List:			

Your Child's Dental History

Gum Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	TMJ	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding Gums	Yes <input type="checkbox"/> No <input type="checkbox"/>	Teeth Grinding	Yes <input type="checkbox"/> No <input type="checkbox"/>
Easily Gags	Yes <input type="checkbox"/> No <input type="checkbox"/>	Difficulties Chewing Food	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sensitive and/or Painful Teeth	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lip Sucking	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nail Biting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thumb Sucking/Pacifier Use	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mouth Breather	Yes <input type="checkbox"/> No <input type="checkbox"/>	Speech Impairments	Yes <input type="checkbox"/> No <input type="checkbox"/>
Brushing two times per day	Yes <input type="checkbox"/> No <input type="checkbox"/>	Flossing Daily	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tobacco Use	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sticky Food Consumption	Yes <input type="checkbox"/> No <input type="checkbox"/>
		How often:	
		Sweet Consumption	Yes <input type="checkbox"/> No <input type="checkbox"/>
		How often:	
		Soda/Pop Consumption	Yes <input type="checkbox"/> No <input type="checkbox"/>
		How often:	

Type Used	How Often?

For office use only:

Sealants Placed: 2 3 14 15 18 19 30 31

Health History reviewed by: _____ Dentist's Initials _____ Date: _____

WAIVER

Please read the waiver below and initial after each permission if agreed to.

I give permission for my child to be treated on the dental bus provided by Bethany for Children & Families' Give Kids a Smile Dental Program. _____ Initial

I give permission for Bethany for Children & Families to transport my child from their school to the dental bus if it needs to be parked off-site. _____ Initial

I give permission for my child to be treated in a dental office/clinic if follow up work is needed. _____ Initial

I give permission for Bethany for Children & Families to transport my child to a follow up dental appointment, if I am not able to take or do not have transportation. Transportation will be arranged on a case by case basis. _____ Initial

If my child needs a specialist: Pedodontist (child dentist), endodontist (root canal), Oral Surgeon (tooth extractions), Periodontist (Gum Disease), or Orthodontist (braces), I agree to go with my child to this appointment. _____ Initial

I give permission for audits to be performed and professional providers to return to my child's school to recheck his/her sealants and reseal if needed. _____ Initial

X Signature _____ **Date** _____

Parent/Guardian/Legal Custodian Signature

I, as the parent or guardian, have received a copy of the Give Kids a Smile® Notice of Privacy Practices.

Permission and acknowledgement valid for one year from the date of signature

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Give Kids a Smile®
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Dentists participating in the Give Kids a Smile® program may be required by applicable federal and state law to maintain the privacy of your health information. Protection of patient privacy is important to participants in the Give Kids a Smile® Program. This notice summarizes the privacy practices that will be followed by participants in the Give Kids a Smile® Program, and your rights concerning your health information. This Notice will apply to health information collected in connection with the Give Kids a Smile® Dental program, and will remain in effect until we replace it.

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 using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment. For example, we may use or disclose your health information to another dentist, physician or other health care provider providing treatment to you.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. 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.

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 involved in your treatment to the extent necessary to help with your healthcare.

Persons Involved In Care: We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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 domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of the Notice for assistance in reaching the dentist or facility holding your health information.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last 6 years, but not before April 14, 2003.

Restriction: You may request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You may request that we communicate with you about your health information by alternative means or to alternative locations. We may agree to reasonable requests.

Amendment: You may request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to 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.