School _____
Grade _____

Ronald McDonald Care Mobile®

University Hospitals Rainbow Babies & Children's

Consent Form

PLEASE COMPLETE FRONT & BACK IN INK

University Hospitals Rainbow Babies & Children's Hospital is bringing its Ronald McDonald Care Mobile to your child's school. Dental professionals will be offering exams and services such as sealants, fluoride varnish, and cleanings. While any child can participate, these services are intended for children without a regular dentist who would not otherwise receive this care. If you choose to have your child treated, you will receive a report stating what services were provided, along with a dental referral if needed.

1

Child's name: _____ Date of birth: _____ Gender: ☐ male ☐ female
Child's social security number: _____-_____-_____ Your email address: _____
Parent/guardian name: _____ Daytime phone: _____
Parent/guardian address: _____ City: _____ Zip: _____

2

Race/ethnicity (please check all that apply):

☐ Hispanic/Latino ☐ Black/African American ☐ Asian/Pacific Islander ☐ White
☐ Multiracial ☐ American Indian or Alaskan ☐ other

3

Insurance helps cover the cost of this program. This section must be completed for your child to receive care on the Care Mobile.

☐ My child does NOT have dental insurance.

☐ My child has dental insurance:

If your child is covered by **MEDICAID** or **TRICARE** dental insurance provide information below:
Circle One: Paramount/Molina/Buckeye/United Healthcare/CareSource/TRICARE/Other _____
Member Name: _____ Billing # or ID #: _____
MMIS Number: _____ Effective Date: _____

If your child is covered by **PRIVATE** dental insurance please provide subscriber's information below:
Dental insurance name: _____ Policy holder name: _____
Birthdate: _____ SSN#: _____ Member ID #: _____ Group #: _____
Subscriber's Employer: _____ Claims Address: _____ Claims Phone #: _____

4

Your child's medical history (check all that apply):

☐ ADD ☐ Seizures/Epilepsy ☐ Asthma ☐ Artificial Joints
☐ ADHD ☐ Heart Murmur ☐ Rheumatic Heart Disease (date _____)
☐ Congenital Heart Defect ☐ GERD/Reflux ☐ Diabetes ☐ Allergies_____
☐ Tuberculosis ☐ HIV/AIDS ☐ Sickle Cell Disease _____
☐ Bleeding/Hemophilia ☐ Cancer ☐ Sickle Cell Trait ☐ Allergy to Latex
☐ Other Medical Condition_____

If you checked any boxes above, please explain: _____
List all medications your child is currently taking: _____
_____
Name of medical doctor or clinic where your child receives care: _____

5

When did your child last visit a dentist? ☐ in the past 6 months ☐ in the past year ☐ more than a year ago ☐ never
Dentist/clinic name: _____

6

Please tell us anything you think we should know about your child's health or previous dental experiences:
_____

7 **Please review and sign the reverse side of this form.**

UNIVERSITY HOSPITALS CLEVELAND MEDICAL CENTER
RONALD MCDONALD CARE MOBILE

Authorization for Treatment

I am the parent, legal guardian or authorized representative of the child named on the front of this page. I authorize University Hospitals Cleveland Medical Center ("Hospital") and its affiliated dentist, dental hygienist and other designated health care professionals to perform basic diagnostic and therapeutic dental treatment services and procedures on the Hospital's Ronald McDonald Care Mobile that they deem necessary and/or appropriate for the care of my child. These services and procedures may include:

- Cleaning of the teeth and topical fluoride
- X-rays of the teeth and surrounding areas of the mouth and jaw
- Applications of plastic "sealant" to the grooves of the teeth
- Treatment of diseased or injured teeth with dental restoration (filling or caps)
- Pulpotomy (root canal for baby tooth)
- Extraction or removal of diseased or injured teeth
- Use of local anesthesia, by injection, to numb the teeth worked on

Except in the case of an emergency, I understand no other treatment or procedures will be performed without my consent. I understand that University Hospitals Cleveland Medical Center is a teaching hospital affiliated with the Case School of Dental Medicine and that dentists and other health care professionals in training may participate in providing care to my child. I consent to the use of my child's medical records for educational purposes. I acknowledge that Hospital is not responsible for acts or omissions of dentists and other healthcare professionals who are not employees or agents of the hospital.

Authorization to Release Information

I acknowledge that I have received Hospitals' Notice of Privacy Practice, which details how my child's private health information may be used. I understand that my child's medical records will be accessible to authorized Hospital personnel through computers and that Hospital will comply with certain safeguards established by Federal, State and local law as well as hospital policy.

I authorize Hospital, its affiliated health care providers and its authorized representatives to release my child's patient information to appropriate parties for the purpose of treatment, billing and collecting payment for services and health care operations.

I authorize Hospital and its affiliated providers to release my child's patient information to the CASE WESTERN RESERVE UNIVERSITY DENTAL OUTREACH PROGRAM and the RONALD McDONALD CARE MOBILE PROGRAM to facilitate their involvement with and support of this program, and to exchange my child's patient information with school officials, other medical and dental providers and outreach coordinators for the purpose of coordinating my child's dental care.

I acknowledge that Hospital and its affiliated providers may release information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions and/or infectious diseases including but not limited to blood borne diseases.

Assignment of Benefits

I understand that I will be billed for services provided. I hereby authorize and request my insurance company, other third party payor or governmental health care program (including Medicare/Medicaid/TRICARE) to pay directly to Hospital and/or **MARGARET E. FERRETTI, DMD** any dental benefits otherwise payable to me for these services.

I authorize Hospital and its affiliated providers to release all medical and other information necessary to secure the payment of benefits, and I authorize the use of this signature on all insurance submissions.

I am the child's parent, legal guardian or authorized representative with authority to sign this document.

_____ _____

PRINT NAME

RELATIONSHIP TO CHILD
(PROVIDE CUSTODY PAPERWORK IF APPLICABLE)

_____ _____

SIGNATURE

DATE

The signature is valid two years from the date of signature, unless revoked by me at an earlier date. I know I have the right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

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