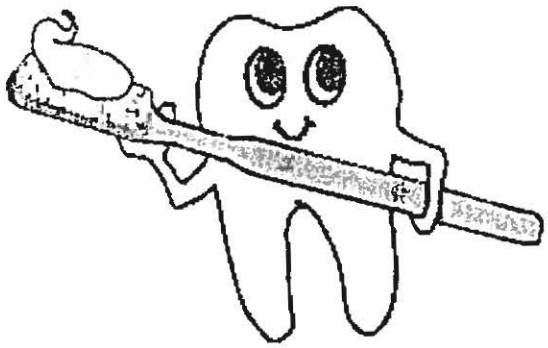
# STAR WELLNESS MOBILE DENTAL CLINIC IS COMING TO YOUR CHILD'S SCHOOL



**Star Wellness Dental Van is back for the 2019-2020 School year to provide top notch and convenient dental care!**

## Services Provided:

- Dental Exams, X-Rays, & Cleanings
- Sealants
- Fillings
- Further treatment if needed

## Who is Eligible? EVERYONE!

We believe all children are deserving of accessible dental care. We have a dedicated team to help.

- Children who have Medical Assistance, AmeriHealth Caritas, Avesis, Geisinger, United HealthCare, Aetna Better Health, Gateway, Capital Blue Cross, Cigna, Delta Dental, Guardian, MetLife and United Concordia.
- No Insurance? Or have an insurance we do not participate with? We can help!
    - We believe all children are deserving of accessible dental care. We have a dedicated team to help.
        - Please contact our Patient Access Coordinator, Jacqueline Grier at 484-464-5656 for any questions or assistance.

**TO HAVE YOUR CHILD SEEN FOR SERVICES IN THE DENTAL VAN: PLEASE RETURN THE ATTACHED FORMS TO THE SCHOOL IMMEDIATELY, OR CONTACT YOUR CHILD'S SCHOOL NURSE.**

**Affiliated with St. Luke's University Health Network**

STAR WELLNESS

# DENTAL VAN HEALTH SERVICES
## STUDENT INFORMATION & CONSENT

**DENTAL VAN HEALTH SERVICES — Please complete and return to the school health room**

Student's Name: _____ Date of Birth: _____ ☐ Male ☐ Female

School: _____ Grade: _____

**DENTAL HEALTH CARE SERVICES:**

___ **YES,** I consent for my child to receive **DENTAL SERVICES** on the Star Wellness mobile van, which may include dental examinations, x-rays, cleanings, sealants, fillings and tooth removal is necessary.

___ **NO,** I do not wish for my child to receive dental services on the Star Wellness dental van.

**MEDIA CONSENT:**

___ **YES,** I hereby consent for Star Wellness and its affiliates to take photographs, interview, or make video and/or audio recordings of my child.

___ **NO,** I do not wish for my child to be photographed, videotaped and/or interviewed by Star Wellness.

**Student Information Dental Van Health Services**

Name of Parent/Guardian: _____ Relationship to Child: _____

Address: _____
Street Number City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Person: _____ Phone Number: _____
Other than Parent / Legal Guardian

**An annual Medical History form must be updated yearly on your child in order to continue receiving care on the dental van. Students with expired medical histories will not be scheduled for dental services.**

Medical Doctor or Clinic: _____ Office Location: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

**Dental Insurance Information (please complete as much as you know):**

Name of Insurance: _____

Policy Number: _____ Group Number: _____

Does your child currently receive dental care at another dentist besides Star Wellness? ☐ Yes ☐ No

**YOUR CHILD MAY NOT USE THE DENTAL VAN IF THEY HAVE SEEN A PRIVATE DENTIST WITHIN THE PAST 6 MONTHS.**

Date of last dental visit at provider other than Star Wellness: _____

*This consent will be in effect until the student graduates or ceases to be enrolled at the student's present school district or until this consent is revoked by the parent/legal guardian by sending a written notification to the student's school nurse.*

By signing this consent, I agree to the terms and conditions regarding the **PAYMENT FOR SERVICES** and **SHARING of HEALTH INFORMATION** as explained in the accompanying **PROGRAM DESCRIPTION** pages. I have received the **Notice of Privacy Practices,** which is included. I understand that signing this consent form is not a guarantee my child will be scheduled for treatment within a certain time frame.

X_____ _____ _____ _____
Parent/Guardian Signature | Date | Time | Parent/Guardian's Printed Name

_____ _____ _____ _____
Student's Signature (if 18 or older) | Date | Time | Student's Printed Name

STAR WELLNESS

# DENTAL VAN HEALTH SERVICES

## MEDICAL HISTORY FORM & HIPAA PRIVACY AUTHORIZATION

**Child's Medical Information (please answer all questions):**

1. Is your child allergic to any medications including penicillin? ☐ Yes ☐ No
   If yes, please list: _____
2. Does your child have any allergies including nuts, food and seasonal? ☐ Yes ☐ No
   If yes, please list: _____
3. Does your child currently take any medications? ☐ Yes ☐ No
   If yes, list names of medications: _____
4. Has your child had any operations, serious injuries or hospitalizations? ☐ Yes ☐ No
   If yes, please explain: _____
5. Does your child have or had any of these problems? (Please check all that apply)

| | | | |
|---|---|---|---|
| ☐ ADHD | ☐ Heart Condition | ☐ Pregnancy | ☐ Learning Disabilities |
| ☐ Autism | ☐ Heart Murmur | ☐ Sinus Trouble | ☐ Mononucleosis (mono) |
| ☐ Asthma or wheezing | ☐ Mitral Valve Prolapse | ☐ Stroke | ☐ Tuberculosis (TB) |
| ☐ Bleeding problems | ☐ High Blood Pressure | ☐ Ulcers | ☐ Hepatitis (A, B or C) |
| ☐ Cancer _____ | ☐ Kidney Disease | ☐ Rheumatic Fever | ☐ HIV/Aids |
| ☐ Diabetes | ☐ Eye Problems | ☐ Behavioral Problems | ☐ Other Conditions: _____ |
| ☐ Liver Disease | ☐ Psychiatric Problems | ☐ Hearing Impaired | _____ |

## HIPAA PRIVACY AUTHORIZATION & MEDIA RELEASE FORM

1. **Authorization to Disclose.** I authorize Star Wellness and its affiliates to use and disclose health information about my child obtained by Star Wellness in providing health services to my child. The purposes of such uses and disclosures would be for communicating with my child's school and its employees and agents, including the guidance counselors and school nurse, as Star Wellness and the school determine is in my child's interests.
2. **Refusal to Sign.** I understand that I may refuse to sign this authorization. Star Wellness may not refuse to treat my child based on my refusal to sign this Authorization.
3. **Expiration of Authorization.** This Authorization shall be in force and effect until my child graduates or ceases to be enrolled at his/her present school, at which time this Authorization expires. Once this Authorization has expired, Star Wellness may no longer use or disclose my child's health information for the purposes listed in this Authorization unless I sign a new Authorization. However, materials that were created prior to the expiration of this Authorization may continue to be used or disclosed for the purposes listed in this Authorization.
4. **Revocation of Authorization.** I understand that I have the right to revoke this Authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my Authorization. If I wish to revoke this Authorization, I will send a written request to: Star Wellness, 511 East 3rd Street, Suite 301, Bethlehem, PA, 18015, Attention: Dental Program Director.
5. **Further Disclosure.** I understand that information used or disclosed pursuant to this Authorization may be further reproduced, copied or disclosed by those who receive or view the information, and the laws governing patient privacy may no longer protect the information.

X_____ _____ _____ _____

Signature of Parent or Guardian | Date | Time | Printed Name of Parent or Guardian and his or her relationship to child

_____

Child's Name