Ronald McDonald Care Mobile® of North Dakota

A

Patient Information Form

Please fill out this form completely. If you have questions, please ask for help. Thank You!

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

School Attending _____ **Grade** _____ **Age** _____ **Sex** (Circle) M F

Ethnicity: Which one of these groups would you say best represents your child's race? (Circle one)

White *Black or African American* *Asian* *American Indian or Alaska Native* *Hispanic/Latino* *Other*_____

Home Address

_____
Street/ P.O. Box City State Zip

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

Cell (_____) _____

Parent Name _____

Note: Dental visits should start at age 1.

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? _____

Dental History	Yes	No	Please explain answers
Is this the patient's first dental visit? If no, how long has it been since the patient last saw a dentist?			
Has the patient had any unpleasant experiences in a dental or medical office?			If "yes" please explain.
Does the patient brush daily?			If "yes" how often?
Does the patient floss?			If "yes", how often?
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-Aid, fruit drink, Gatorade, sport drinks)?			How many does the patient drink per day?
Does the patient drink milk daily?			How many times per day?
Has your child's 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?			How many times?
Before the Ronald McDonald Care Mobile did you seek dental care for the patient?			If "yes" where?(Circle) Clinic, Dental Office, Doctor's Office, Emergency Room, School Nurse, No care, Other:_____

Reason for Visit: Check any that apply (√)

☐ First examination	☐ Accident to teeth	☐ Routine exam
☐ Toothache	☐ Bleeding around the teeth	☐ Teeth appearance
☐ Mouth pain/face swelling	☐ No Regular Dentist	
☐ Other (Specify)_____		

OVER

Health History

Current Dentist _____ **Patient's Current Physician** _____

Health History	Yes	No	Please Explain "yes" Answers
Does the patient have a current medical condition?			
Is the patient taking any medications?			If "yes" list medications and dosages
Has the patient ever been hospitalized or had surgery?			If "yes" list reasons and surgeries
Does the patient have any allergies?			If "yes" list allergies
Does the patient have any special needs that would require special arrangements for dental care? (e.g., autism, etc.)			If "yes" describe special needs
Is the patient pregnant or maybe pregnant?			If "yes" how many months?

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

□ Latex allergy	□ Cerebral Palsy	□ Fainting	□ Mono
□ Anesthetic allergy	□ Chronic ear infections	□ Hearing problems	□ Rheumatic fever
□ AIDS/HIV	□ Cold sores/Herpes	□ Heart problems	□ Respiratory problems
□ Anemia	□ Convulsions	□ Hepatitis	□ Sinus problems
□ Asthma	□ Diabetes	□ High blood pressure	□ Sore throats
□ Bladder problems	□ Eating disorders	□ Kidney disease	□ Tuberculosis
□ Birth defects	□ Epilepsy/seizures	□ Liver disease	□ Stomach/intestinal disorders
□ Cancer	□ Excessive bleeding	□ Migraines	□ Other_____

Please explain "yes" answers:

_____

Is there anything else about your health we should know?

_____

Behavioral History	Yes	No	Please Explain "yes" answers
Does the patient use tobacco products (cigarettes, chewing tobacco)?			
Does anyone smoke in the household?			
Does the patient use alcohol and/or drugs?			
Have you noticed any major changes in the patient's behavior, withdrawal, anxiety, grades, moods, friendships, or activities?			

Insurance: Please circle any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided and **provide a copy of your dental insurance card.**

Medicaid/SCHIP	**Private DENTAL Insurance** (please provide copy of card)	**None**
Medicaid Number/Policy Number:		
Dental Ins. Name:	Policy #:	Group #:
Dental Ins. Address:		Ins. Phone #:

Parent/ Legal Guardian signature _____ Date _____

Ronald McDonald Care Mobile of North Dakota

B

Treatment Consent and Agreement Form

The treatment may consist of dental x-rays, diagnosis, topical fluoride application and other preventive measures as well as restorations (fillings), extractions and space maintainers as recommended by the Ronald McDonald Care Mobile staff. I understand that the Ronald McDonald Care Mobile dentists will use restorative treatment and behavior management that is reasonable and necessary.

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 have checked the box next to each type of service for which I am granting authorization. Each item needs to be answered in order to receive dental care.

Yes	No	
		Dental Exam, including dental x-rays.
		Preventive Services: teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.
		Restorative Services: fillings, stainless steel crowns, pulpotomy. Anesthesia is used for these procedures.
		Extraction of Primary Teeth: Removal of primary (baby) teeth that cannot be restored through other treatments. Anesthesia may be used for this procedure.
		Extraction of Permanent Teeth: Removal of permanent teeth that cannot be restored through other treatments. Anesthesia is used for this procedure.

I understand that local anesthetics and nitrous oxide may be used as deemed appropriate by the Ronald McDonald Care Mobile dentists in performing the recommended treatment(s). I understand there may be risks involved with dental treatment.

I consent that _____, who is under the age of eighteen years, may participate in the
(Print child's name)
dental services provided by the Ronald McDonald Care Mobile, and consent that their dentists and other agents and employees may furnish to Care Mobile employees (and/or authorized organizations) all information concerning the child's case history, dental examinations, written reports (and any accompanying photographs) with respect to the dental examination and the exam results. An authorized organization is one approved by the Ronald McDonald Care Mobile and Bridging the Dental Gap.

I consent and authorize the Ronald McDonald Care Mobile to file and collect North Dakota Medicaid/SCHIP reimbursement for dental services provided. I also certify that I understand and agree to the conditions described above.

Are you currently the legal guardian for this child? YES NO
Can you sign for medical treatment? YES NO

Parent/guardian name _____ (Please print)

Relationship to child_____

Signature_____Date_____

Ronald McDonald Care Mobile of North Dakota

HIPAA
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name_____

I, _____have received a copy of the Ronald McDonald Care
(Parent/legal guardian name)

Mobile Privacy Practices.

Parent/legal guardian signature
_____Date_____

Note: This authorization is valid for six years from date of signature unless revoked in writing prior to that date. This authorization may be revoked by writing to: Ronald McDonald Care Mobile of North Dakota, PO Box 7323, Bismarck, ND 58507.

Authorization for Release of Protected Health Information

By signing this document, you are allowing the Ronald McDonald Care Mobile staff to give or receive your child's health care records to other health care providers, or child agencies to provide the best care for your child. The records may be sent to another dentist, dental specialist or other health care provider that the Care Mobile staff recommends further treat your child. The information may also be shared with an agency that your child is affiliated with (such as school, Head Start, etc.) for record keeping purposes.

Patient's Name _____ Social Security Number _____-_____-_____

I hereby authorize:
Ronald McDonald Care Mobile of North Dakota
PO Box 7323, Bismarck, ND 58507
Phone: 701.258.8551
to receive from or release to the appropriate health care provider or agency, my child's records to facilitate his or her health care needs and/or treatments.

Name of parent/legal guardian_____
(Please print)

Parent/legal guardian signature_____Date_____

If there are providers or agencies that you do NOT want your child's records released to or received from please list here:

_____ _____

Photo Consent and Release

I consent to the use of pictures, video or audio recordings of myself or my child for program promotion, including print, audio, video and web promotion. I also agree that any writing or other material in connection with the Ronald McDonald Care Mobile of North Dakota (including any correspondence from our family to Ronald McDonald House Charities® of Bismarck) may be used in promotional materials.

Signature of parent/legal guardian _____ Date_____

The Ronald McDonald Care Mobile (RMCM) is made possible by a grant from Ronald McDonald House Charities, Inc., (RMHC, Inc.), a non-profit, tax-exempt charitable corporation. RMHC, Inc. has no responsibility or liability for the operation of this RMCM or any of the medical or dental activities conducted on the RMCM.

8-2023