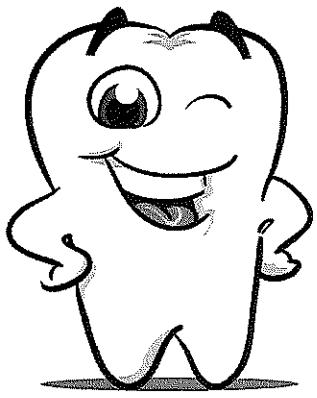
Ascension
St. Vincent

Paperwork must be completed EVERY YEAR for all patients. Please fill out enclosed pink packet. Sign, date, and return in the envelope provided.

Thanks,

Acension St. Vincent Mobile Dental Clinic

812-485-5843



Office use only
Chart #:_____
RC Due:_____
HAA/Date:_____/_____

Ascension St. Vincent 2020/2021

MOBILE DENTAL CARE FOR KIDS (812)-485-5843

SCHOOL:_____ **GRADE**_____ **Attends After School? ☐ Yes ☐ No**

PATIENT INFORMATION **Form must be completed by LEGAL Parent or Guardian **

Child's Name _____ Preferred Name:_____ Gender: ☐ Male ☐ Female
First Name **Last Name**
Birth Date_____ Age _____ Child's Social Security #_____

Child's Home Address
Street **City** **State** **Zip Code**
Siblings (first and last names): _____

PARENT or GUARDIAN INFORMATION

Father's Name_____
Address (if different from patient's)
_____
Home Phone _____ Cell Phone _____
Employer _____Work Phone_____
Social Security #_____ Birth date _____

Mother's Name_____
Address (if different from patient's)
_____
Home Phone _____ Cell Phone _____
Employer _____Work Phone _____
Social Security # _____ Birth date _____

How would you like to be contacted? Telephone ☐ Email ☐ Text Message ☐ (Please provide cell phone company for Text)
Email: _____

EMERGENCY CONTACT (in the event we cannot reach you, please provide an alternate contact)

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

DENTAL INSURANCE INFORMATION

Does your child have **Hoosier Healthwise? ☐ Yes ☐ No** *If yes, please provide* **Patient ID#** _____

Commercial Dental Insurance:

Policy Holder/Subscriber Name _____ Employer _____
SS # or Policy ID Number _____ Date of Birth _____ Group Number _____
Insurance Plan Name & Address _____ City _____ State _____ Zip _____
Insurance Phone Number _____

★If your child is not covered with dental insurance, please select the following options:

☐ Assist enrolling for Hoosier Healthwise ☐ Call with more Information about payment options

(St. Vincent Mobile Dental Care is a full service dental facility in which fees are charged per service(s) rendered on the date your child is treated.)

DENTAL HISTORY (If your child is to be seen on our dental bus, please be sure your child is NOT currently seeing another dentist.)

Has your child seen another Dentist in the last 6 months? ☐ Yes ☐ No Dentist Name _____ Last visit_____
Has child complained about dental problems? ☐Yes ☐ No If Yes, please explain: _____
Any mouth habits – thumb/finger sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? ☐ Yes ☐ No
If Yes, please explain: _____

☞ *We will be unable to see your child unless **both sides** of this form and the **white form** are completed, **SIGNED** and **DATED**.*

MEDICAL HISTORY

Has your child been informed by a physician that he/she needs to be **PRE-MEDICATED** before dental treatment due to a heart murmur or other medical condition? ☐ Yes ☐ No If Yes, please explain: _____

If Yes, please provide the treating Physician's information: Name:_____ Phone:_____

Child's Physician _____ City/State _____ Phone _____

Patient under the care of a physician now? ☐ Yes ☐ No Ever been hospitalized? ☐ Yes ☐ No

If yes, please explain_____ If yes, why & date?_____

Is child receiving any medication or drugs? ☐ Yes ☐ No Ever had surgery? ☐ Yes ☐ No

List Current Medications (Including over the counter and /or herbal) If yes, why & date? _____

_____

Allergies (check all that apply) ☐Latex ☐ Medications ☐ Foods ☐ Environmental Allergies ☐ Other

Please describe: _____

HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CIRCLE

AIDS/HIV	Cerebral Palsy	Diabetes	Hemophilia	Rheumatic Fever
ADD or ADHD	Chronic Illness	Drug/Alcohol Abuse	Hepatitis	Seizures
Anemia	Cognitive Disorders	Emotional Disorders	Joint Replacement	Sickle Cell Anemia
Asthma	Communication Disorders	Fainting or Dizzy Spells	Kidney Disease	Tuberculosis
Autism	Convulsions	Hearing Problems	Mental Disorders	Vision Problems
Behavioral Disorders	Depression	Heart Murmur	Pregnancy	
Blood Transfusion	Developmental Disability	Heart Problems	Psychiatric/Psychological Care	
Cancer				

Other_____

Special Needs Explain _____

AUTHORIZATION

I have reviewed this patient information and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for my child, and I agree to notify the dentist if any change in my child's health status should occur. I understand that St. Vincent must at times collaborate with other outside facilities to coordinate treatment and hereby authorize release of information to these facilities when necessary for treatment of my child. I authorize the dental staff to perform any necessary dental services my child may need. I acknowledge St. Vincent Mobile Dental Care for Kids is a full service dental facility in which fees are charged per service(s) rendered on the date my child is treated. I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions. I recognize that St. Vincent coordinates dental appointments for my child with the school entity and staff and authorize my child to be seen on the dental bus during school or afterschool hours without my presence. **I understand this dental information is required to be updated yearly and this form will expire one year from the date I sign below**, in which a new form must be completed in order for my child to receive dental treatment by St. Vincent Mobile Dental Care for Kids. **By signing below, I have read and reviewed the dental form and understand its contents** (Please call our facility if you have any questions regarding our services or this paperwork. Dental fees are only provided upon request.)

X _____ **DATE:** _____

PARENT or GUARDIAN SIGNATURE

For Staff Use Only

***Reviewed By* (please initial and date):** ***Verbal Consent* given by (parent/guardian name):**_____

Office _____ **Date**_____ **Staff Initials**_____

Driver _____ **Date**_____ **Staff Initials**_____

Clinical _____ **Date**_____ **Date**_____

ST. VINCENT EVANSVILLE
3700 WASHINGTON AVENUE
EVANSVILLE, INDIANA 47750
(812) 485-4000

Consent For Admission To Hospital, Medical Treatment, Release Of Information And Responsibility

Name:_____ Date:_____ Time:_____

1. I/We the undersigned, voluntarily give my (or the patient's) consent for inpatient or outpatient diagnostic procedure(s) and/or medical or surgical care and treatment as ordered and under the supervision of an admitting or attending licensed practitioner or whomever he/she designates, who is (are) credentialed to admit and treat patients at St. Vincent of Evansville.

2. I/We are aware that the practice of medicine and surgery is not an exact science and I/We acknowledge that no guarantees or assurances have been made to me/us with regard to the results that may be obtained from treatments or examinations in the hospital.

3. I/We acknowledge that St. Vincent of Evansville, does not assume responsibility for loss or damage to personal property kept in the patient's room. I/We further acknowledge that while the safe is available for the keeping of money and valuables of the patient, St. Vincent of Evansville, assumes no responsibility for any possessions deposited therein.

4. I/We consent to allow students from formal education programs for health care professions to participate in my/the patient's care, under the supervision of appropriately licensed and/or credentialed members of such disciplines.

5. If applicable, I/We authorize St. Vincent of Evansville pathologists to use their discretion in the disposal of any specimen or tissue obtained from myself (the patient) in the course of diagnosis or treatment.

6. I/We understand that some insurance companies require prior authorization for inpatient admissions, outpatient services or specific procedures, and that maximum reimbursement may not be received if authorization is required and I/We do not have it. I/We assume the responsibility of obtaining such authorization if necessary and understand that St. Vincent of Evansville cannot obtain such authorization for me/us.

7. I/We assign all insurance benefits due to or received by me/us to St. Vincent of Evansville, and/or the doctors involved with my/the patient's care including those performing x-ray services, anesthesia services, pathology services, emergency services, or other similar services as total or partial payment for services provided. I/We understand that this assignment may not constitute full payment of my/the patient's bill, and does not relieve me/us from liability for the unpaid balance. If insurance benefits to which I/the patient are entitled are paid directly to me/us, such benefits will upon receipt be immediately delivered to St. Vincent of Evansville (or the appropriate physician) by me/us until the full amount of all charges incurred are paid in full.

   I/We agree to pay directly to St. Vincent of Evansville and/or said doctors the charges incurred for services received, at their established rates. I/We will pay all attorney fees and court costs incurred by St. Vincent of Evansville or said doctors in collecting any unpaid balances for services I/the patient received.

8. I/We acknowledge that I/we received written information regarding my/the Patient Rights protected by St. Vincent of Evansville and written information on the Indiana State Law pertaining to Advance Directives, which gives me (the patient) the right to choose in advance, such things as living will, the appointment of a health care representative or power of attorney for health care purposes. Additionally, in the event that I (the patient) have already executed a valid Advance Directive, I will provide a copy of this document at this admission.

9. I understand that I may request to review my Medical Record during the course of this Hospital stay.

10. If applicable, I/we authorize the delivery, care and treatment of both mother and newborn infant as explained by the designated physician(s). I/We consent to the performance of any other procedures considered necessary by the physician on the basis of findings during the course of care and treatment of mother and/or infant. I/We specifically understand that I/we are consenting not only to my/the mother's care, but the care of the newborn as well.

11. **ACCIDENTAL EXPOSURE OF HEALTHCARE STAFF**: In the course of hospital care and treatment, physicians, nurses and other healthcare staff may accidentally be exposed to a patient's blood or body fluids (through needle sticks, blood splattering, etc.). Communicable diseases, including Hepatitis B, C, HIV Virus, and others are known to be transmitted through exposures of this type. I authorize testing to include HIV and Hepatitis B and C if a healthcare worker should be accidentally exposed to my blood or bodily fluid. I understand that if tests are required, they will be performed at no cost to me. A licensed Independent Practitioner will be in contact with me if the results indicate this.

12. I/We understand that St. Vincent of Evansville may share my (the patient's) medical information for research purposes under limited circumstances and subject to a special approval process. This process reviews research projects and their use of medical information.

13. I/We understand that St. Vincent of Evansville participates in an electronic health information exchange that facilitates access to medical information by other providers and that the exchange allows my (the patient's) medical information to be available electronically to those who need to treat me (the patient).

14. I/We authorize the hospital and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

   I have read this paragraph **Initials** ☐

15. **Independent Status of Physicians: I understand that some or all, of the physicians who will provide services to me while at St. Vincent of Evansville are independent contractors and are not agents or employees of St. Vincent of Evansville. St. Vincent of Evansville consents to independently contracted physicians or groups to perform specific services, including but not limited to, Radiology, Emergency Medicine, and Anesthesia, for patients. Those physicians are not employed by St. Vincent of Evansville. Rather they are independent medical practitioners who have been granted the privilege to use the facilities at St. Vincent of Evansville for my care and treatment. I can expect to receive a separate bill from those physicians or physician groups.**

   I have read this paragraph **Initials** ☐

St. Vincent of Evansville's Notice of Privacy Practices provides information about how protected health information about me (the patient) may be used and disclosed. By signing this form, I acknowledge that I have been offered and/or received St. Vincent of Evansville's Notice of Privacy Practices.

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ THE ENTIRE FORM AND UNDERSTAND ITS CONTENTS. PLEASE ASK QUESTIONS IF YOU ARE NOT SURE ABOUT ANYTHING ON THIS FORM.

If signed by person other than the Patient, please check the appropriate box indicating why the Patient can not give own consent:
☐ Patient's Age (Minor) ☐ Medical Condition

Witness	Patient/Closest Relative/Legal Guardian	Date/Time

1CNT

Ascension St. Vincent

Effective Date: September 1, 2013

JOINT NOTICE OF PRIVACY PRACTICES

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.

OUR RESPONSIBILITIES

St. Vincent takes the privacy of your health information seriously. We understand the importance and sensitivity of your health information. We are required by law to maintain your privacy and to provide you with this Notice of Privacy Practices ("Notice"). We are required to abide by the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We protect the privacy of your health information because it is the right thing to do. We use your health information (and allow others to have it) only as permitted by federal and state laws. When we care for you, we gather and create some of your health information. This Notice includes examples in each category below of how we will use and share your information. Not every use or disclosure is listed below; however, all permissible uses and disclosures will fall within one of the categories.

- **For Treatment**. We use information about you to understand your health condition and to treat you when you are sick. We may share your health information with doctors, nurses, aids, technicians or other employees who are involved in taking care of you. We might use your health information to manage or coordinate your treatment, health care or other related services. We might share your medical information with your physician or other health care provider who is providing treatment to you, whether or not we are involved with your treatment at the time. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery. We may receive and share prescription information to help you avoid harmful drug interactions. Different departments of the facility may also share health information about you in order to coordinate different things you might need such as medications, x-rays, laboratory work, etc.
- **For Payment**. To receive payment for our services, we may send your health information to an insurance company or other third party. We may also disclose your medical information to another health care provider or payor of health care for their own payment activities. For example, your insurance company may request information about your surgery and we must provide that information to obtain payment. The physician who reads your x-ray may need to bill you or your insurance company for reading your x-ray; therefore, your billing information may be shared with the physician who read your x-ray.
- **For Health Care Operations**. We may use and disclose your health information to enable St.Vincent to make sure you receive competent, quality health care, and to maintain and improve the quality of health care we provide. We may assess the care and outcomes in your case and others like it and then use the results to continually improve the quality of care for all patients we serve. We may also provide your health information to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may combine health information we have with that of other facilities to see where we can make improvements.

The law sometimes requires us to share information for specific purposes, including reporting to:

- The Department of Health to report communicable diseases, traumatic injuries, or birth defects, or for vital statistics such as a baby's birth.
- A funeral director or an organ-donation agency when a patient dies, or to a medical examiner when appropriate to investigate a suspicious death.
- The appropriate governmental agency if an injury or unexpected death occurs at our facility.
- Public health authorities to report child or elderly abuse, or suspected child or elderly abuse, if authorized or otherwise required to report by law.
- Law enforcement official if required to do so by law, for example, to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.
- Governmental inspectors who, for example, make sure our facilities are safe
- Under certain conditions, to military command authorities or the Department of Veterans Affairs, for patients who are in the military or veterans.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made under the authorization, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care.
  You have the right to restrict disclosures of your health information to your health plan for payment and health care operations purposes (and not for treatment) if the disclosure pertains to a health care item or service for which you paid out-of-pocket in full. If requesting a restriction for a health care item or service for which you paid out-of-pocket in full, we will honor your request, unless the disclosure is necessary for your treatment or is required by law.

  For all other restriction requests, **we are not required to agree to your request**. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  Any request for restrictions must be sent in writing to the Privacy Official.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you or your responsible party about your health care in an alternative way or at a certain location. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to Inspect and Copy, Right to Access**. You have the right to inspect and obtain a paper or electronic copy of your medical information that we use to make decisions about your care, when you submit a written request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Right to Amend**. You have the right to ask us to amend your health and/or billing information for as long as the information is kept by us. We may deny your request for an amendment and, if this occurs, you will be notified of the reason for the denial and provided an opportunity to appeal the denial.
- **Right to an Accounting of Disclosures**. You have the right to request a list of certain disclosures that we have made of your health information that were for purposes other than treatment, payment or health care operations or were authorized by you.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

  You may obtain a copy of this Notice at our web site at www.StVincentSWIN.org or contact the Privacy Official.

WHO THIS NOTICE APPLIES TO

This Notice describes St.Vincent practices and those of:

- Any health care professional authorized to enter information into or consult your medical record or who provides treatment to you while you are at or in the facility including but not limited to, attending physicians, radiologists, pathologists, anesthesiologists, surgeons, internal medicine physicians, emergency department physicians, staff members of such physicians, and any other physician or health care provider that is involved in your care at the facility.
  - All locations, departments and units of St.Vincent.
  - Any member of a volunteer group we allow to help you.
  - All employees, staff and other St.Vincent personnel, and any resident, student or trainee that we have allowed to train at the facility.