# DENTAL AND MEDICAL MOBILE SERVICES

NORTHEAST MISSOURI HEALTH COUNCIL
Partners for a Lifetime of health

The Northeast Missouri Health Council (NMHC) is excited to partner with your school to provide a variety of dental and medical services during school hours. Appointments are limited and priority is given to students who return completed paperwork promptly and to those who have the greatest needs.

☐ I want my child seen on the mobile **DENTAL** Unit.

☐ I want my child seen on the mobile **MEDICAL** Unit.

If you marked either box, please fill out the attached packet and return it to your child's school. The packet must be signed by a parent or guardian and turned in to the school nurse or school office before the child can be scheduled for either of the mobile programs.

The Mobile Dental Program will accept MO HealthNet, Home State, UHC Community Plan, and Healthy Blue. There is no cost or financial requirement to the parent if the student is covered by one of these plans. If the child is uninsured, NMHC staff will work with the parent/guardian to verify eligibility and/or apply for appropriate coverage, if applicable.

The Mobile Medical Program will file all medical insurances. If the child is uninsured, NMHC staff will work with the parent/guardian to verify eligibility and/or apply for appropriate coverage, if applicable.

***Please return completed packet to your child's school by***
***_____ / _____ / _____ !***

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**Consent to Treat/Mobile Medical & Dental Unit/Parent Not Present**

_____ _____/_____/_____
Child's Name DOB

_____
Child's School

This document is my consent as parent/guardian of the above-named child for any treatment or procedure deemed necessary by the professional staff of Northeast Missouri Health Council while my child is on the MOBILE MEDICAL & DENTAL UNIT.

MEDICAL - These treatments and procedures include, but are not limited to, wellness exams, vaccinations, sick visits.

DENTAL - These treatments and procedures include, but are not limited to, dental examinations, x-rays, prophylaxis (cleaning), fluoride treatment, fillings, crowns, pulp treatments, and extractions.

Please list below any specific treatment or procedure ***not*** to be completed on your child:

_____

_____ .

_____ _____
PRINTED Parent/Guardian Name Relationship to Patient

_____ _____/_____/_____
Parent/Guardian Signature DATE

## CHILD'S INFORMATION

_____/_____/_____
DATE

_____/_____/_____
SCHOOL TEACHER GRADE

_____/_____/_____
CHILD'S FIRST NAME MI CHILD'S LAST NAME

_____/_____/_____ _____ _____-_____-_____ _____
DOB AGE SS# GENDER

_____/_____/_____
MOTHER'S MAIDEN NAME PREFERRED LANGUAGE CHILD'S RACE & ETHNICITY

_____/_____/_____
CHILD'S PRIMARY DOCTOR CHILD'S PRIMARY DENTIST PREFERRED PHARMACY

YES / NO /YES / NO
DOES CHILD HAVE PRESCRIPTION DRUG COVERAGE? IS CHILD HOMELESS OR DISPLACED?

## PARENT/GUARDIAN NFORMATION

Person filling out this form: PARENT or GUARDIAN (circle one)

_____/_____
PARENT/GUARDIAN FIRST NAME PARENT/GUARDIAN LAST NAME

_____/_____/_____ _____-_____-_____ (_____)_____-_____
PARENT DOB PARENT SS# PHONE # FOR PRIMARY PARENT/GUARDIAN

_____/_____/_____/_____
STREET ADDRESS CITY STATE ZIP

## EMERGENCY CONTACT

EMERGENCY CONTACT _____
RELATIONSHIP TO CHILD_____ PHONE # (_____)_____-_____

## INSURANCE INFORMATION

Is CHILD covered by **Missouri Medicaid/Mo HealthNet (including Healthy Blue, United Healthcare Community Plan, or HomeState Health Plan**)? YES or NO If YES, what is the **DCN #** _____

Is CHILD covered by any other **MEDICAL** insurance? **Attach a copy of front & back of card, OR fill out information below**: NAME OF MEDICAL INSURANCE_____
POLICY HOLDER NAME_____ POLICY HOLDER DOB _____/_____/_____
MEMBER ID #_____ RELATIONSHIP TO CHILD _____
Address to mail claims to: _____/_____/_____/_____
Street Address City State Zip

Is CHILD covered by any other **DENTAL** insurance? **Atach a copy of front & back of card, OR fill out information below**: NAME OF DENTAL INSURANCE_____
POLICY HOLDER NAME_____ POLICY HOLDER DOB _____/_____/_____
MEMBER ID #_____ RELATIONSHIP TO CHILD _____
Address to mail claims to: _____/_____/_____/_____
Street Address City State Zip

# HIPAA & INS/TX AUTH
## Mobile Medical/Dental Unit

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**PATIENT NAME**_____ **DOB** _____/_____/_____
*(Please Print)*

### NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used for: **treatment, payment, and healthcare operations.** NMHC'S NOTICE of PRIVACY PRACTICES is posted in each clinic reception area, is available from any front desk associate, and can be viewed online at nemohealthcouncil.com. I understand Northeast Missouri Health Council, Inc. (NMHC, Inc.) has the right to change its Notice of Privacy Practices from time to time. My signature below indicates I have read and understand NMHC's Notice of Privacy Practices.

**Patient/Guardian Signature**_____**Date** _____/_____/_____

### ASSIGNMENT OF INSURANCE BENEFITS & TX AUTH:

I, the undersigned, authorize my insurance benefits to be paid directly to the provider of the Northeast Missouri Health Council, Inc. (NMHC, Inc.), for services rendered. I understand that I am ultimately financially responsible for any balance due not paid by insurance. I hereby authorize NMHC, Inc., to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

I, the undersigned, consent to Northeast Missouri Health Council providers and staff to perform medical/dental examinations, testing and treatment as directed by my provider. I understand that I have the right to discuss with my provider the purpose, potential risks, and benefits of any ordered tests or treatment options. I understand that if invasive or interventional tests or procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures. I understand that the consent will remain fully effective until it is revoked in writing.

**Patient/Guardian Signature**_____**Date** _____/_____/_____

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**NORTHEAST MISSOURI HEALTH COUNCIL** **FY2025**

As a Federally Qualified Health Center (FQHC), we are required to report economic data on our patients. Please find your household size and appropriate income category on the chart below and report the category such as 1A or 4D, etc. NMHC, Inc. appreciates your cooperation and wants to assure you that we only report de-identified (no names or medical information) data.

| Household Size | A | B | C | D | E | F |
|---|---|---|---|---|---|---|
| **1** | **0 - 15,060** | **15,061 - 18,825** | **18,826 - 22,590** | **22,591 - 26,355** | **26,356 - 30,120** | **30,121 & above** |
| **2** | **0 - 20,440** | **20,441 - 25,550** | **25,551 - 30,660** | **30,661 - 35,770** | **35,771 - 40,880** | **40,881 & above** |
| **3** | **0 - 25,820** | **25,821 - 32,275** | **32,276 - 38,730** | **38,731 - 45,185** | **45,186 - 51,640** | **51,641 & above** |
| **4** | **0 - 31,200** | **31,201 - 39,000** | **39,001 - 46,800** | **46,801 - 54,600** | **54,601 - 62,400** | **62,401 & above** |
| **5** | **0 - 36,580** | **36,581 - 45,725** | **45,726 - 54,870** | **54,871 - 64,015** | **64,016 - 73,160** | **73,161 & above** |
| **6** | **0 - 41,960** | **41,961 - 52,450** | **52,451 - 62,940** | **62,941 - 73,430** | **73,431 - 83,920** | **83,921 & above** |
| **7** | **0 - 47,340** | **47,341 - 59,175** | **59,176 - 71,010** | **71,011 - 82,845** | **82,846 - 94,680** | **94,681 & above** |
| **8** | **0 - 52,720** | **52,721 - 65,900** | **65,901 - 79,080** | **79,081 - 92,260** | **92,261 - 105,440** | **105,441 & above** |
| | *add $5,380 per* | *add $6,725 per* | *add $8,070 per* | *add $9,415 per* | *add $10,760 per* | |

**For families with more than 8 members add the appropriate figure noted in each column per additional member.*

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Date: ____/____/____

Patient Name: _____ DOB: ____/____/____ Gender: _____

**Who is filling out this form?**

☐ Mother ☐ Father ☐ Other guardian (please explain relationship to child) _____

**The child's parents are:**

☐ Single ☐ Married ☐ Divorced ☐ Separated but not divorced ☐ Widowed

Has your child been seen for a well child exam in the last year? ☐ Yes ☐ No Date: _____

**MEDICAL HISTORY – Please Complete if your child is seeing Medical *AND/OR* Dental**

1. Please check any of the following **medical problems** that your child **has** or has **ever** been diagnosed with.

| | |
|---|---|
| **ADD/ADHD** | ☐ Yes ☐ No |
| **Anxiety or Depression** | ☐ Yes ☐ No |
| **Artificial Joint Placement** | ☐ Yes ☐ No |
| **Asthma** | ☐ Yes ☐ No |
| **Back** problems (scoliosis, back pain) | ☐ Yes ☐ No |
| **Blood clotting disorder or Abnormal Bleeding** | ☐ Yes ☐ No |
| **Congenital Heart Defects or Heart Murmur** | ☐ Yes ☐ No |
| **Diabetes** | ☐ Yes ☐ No |
| **Diarrhea** or **Constipation** (having frequent and runny bowel movements, having difficulties having a bowel movement.) | ☐ Yes ☐ No |
| **Ear** infections | ☐ Yes ☐ No |
| **Eating Disorders** (Anorexia, Bulimia) | ☐ Yes ☐ No |
| **Mitral Valve Prolapse** | ☐ Yes ☐ No |
| **Mouth or throat** problems (Strep throat, swallowing problems) | ☐ Yes ☐ No |
| **Muscle and bone** problems (weak muscles, pain in joints) | ☐ Yes ☐ No |
| **Nose** problems (sinus infections, nose bleeds) | ☐ Yes ☐ No |
| **Neurological Disorders** (Autism, head injury, seizures, headaches) | ☐ Yes ☐ No |
| Problems **urinating** (bed wetting, pain when urinating) | ☐ Yes ☐ No |
| **Skin** problems (acne, flaking skin, rashes, hives) | ☐ Yes ☐ No |
| **Sleeping** problems (falling or staying asleep) | ☐ Yes ☐ No |
| **Vision or Hearing** problems (blurry vision, need to wear, glasses, difficulty hearing, deaf) | ☐ Yes ☐ No |
| **Please list any other medical problems or diagnoses that are not listed above:** | |

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2. Has your child ever had any **surgeries**?

☐ No

☐ Yes (If yes, please list the type of surgery and when.)

| **Surgery Performed:** | **When** |
|---|---|
| | |
| | |
| | |

(Please use the back of this form if you need to list additional surgeries.) ☐ Additional list on back

3. Is your child taking any **prescription medicines**?

☐ No. My child does not take any prescription medicines.

☐ Yes - Please list the child's medicines below.

| **Name of medicine** | **Amount / size of pill** | **How many pills or doses does your child take at** |
|---|---|---|
| **Example:** Dexadrine | 10 mg | __1__morning ____noon ____evening __1__bedtime |
| | | ____morning ____noon ____evening ____bedtime |
| | | ____morning ____noon ____evening ____bedtime |

(Please use the back of this form if you need to list additional medications.) ☐ Additional list on back

4. What **over-the-counter medicines** does your child take regularly?

☐ Vitamins

☐ Herbal medicine (please list) _____

☐ Other (please list) _____

☐ None, my child does not take any over-the-counter medicines regularly.

5. Does your child have any **allergic reaction** to any of the following? (Check all that apply.)

☐ Outside or Indoor allergies (for example: grass, pollen, cats)

☐ Food Allergies (for example: peanuts, milk, wheat)

☐ ***LATEX*** (for example: dental gloves)

☐ Medicine or shots (immunizations or dental local anesthetics). (Please list below.)

☐ No, my child has no allergies that I know of.

| **Medicine child is allergic to:** | **What happens when the child takes that medicine** |
|---|---|
| | |
| | |
| | |

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## FAMILY

6. Check all the people that the **child lives with**:

☐ Mother ☐ Father ☐ Brothers (how many? _____) ☐ Sisters (how many?_____)

☐ Other family members or friends (list _____)

7. Please mark the medical history that the child's **immediate family** has been diagnosed with.

| Family Member | Medical Problems |
|---|---|
| Mother: | ☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability<br>☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar)<br>☐ Cancer ☐ Heart problems<br>Other: _____ |
| Father: | ☐Depression ☐Anxiety (nerve) problems ☐Learning disability<br>☐Overweight ☐High blood pressure ☐Diabetes (sugar)<br>☐Cancer ☐Heart problems<br>Other: _____ |
| Sisters: | ☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability<br>☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar)<br>☐ Cancer ☐ Heart problems<br>Other: _____ |
| Brothers: | ☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability<br>☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar)<br>☐ Cancer ☐ Heart problems<br>Other: _____ |

## Dental History: COMPLETE ONLY IF YOUR CHILD IS BEING SEEN ON MOBILE DENTAL UNIT

8. Date of last dental exam: _____ Office/Dentist Name: _____

| Has your child ever: | |
|---|---|
| Been seen by a dentist? | ☐ Yes ☐ No |
| Geen sedated for dental surgery or had dental treatment in a hospital setting? | ☐ Yes ☐ No |
| Had nitrous, ('laughing gas') for dental treatment? | ☐ Yes ☐ No |
| Orthodontic work | ☐ Yes ☐ No |
| Teeth extractions | ☐ Yes ☐ No |
| Does your child have pain with any of their teeth? | ☐ Yes ☐ No |

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## Consent for Immunizations on Mobile Medical Unit

☐ I consent for my child to receive any of the below vaccinations for which they are due.

☐ I **DO NOT** consent for my child to receive vaccinations on the mobile medical unit.

**IF THERE ARE ANY VACCINATIONS LISTED BELOW WHICH YOU DO NOT WANT YOUR CHILD TO RECEIVE, PLEASE DRAW A LINE THROUGH THE NAME AND PLACE INITIALS BESIDE THE LINE.**

Tetanus, Diphtheria, Acellular

Pertussis (Tdap) Human Papilloma

Virus (HPV) Meningococcal

(Menactra)

Meningococcal-B (Bexsero)

9. Please list any other pertinent information about your child that you would like us to know.

_____
_____
_____
_____
_____

Printed Parent/Guardian Name: _____

Parent/Guardian Signature: _____