School of Dental Medicine

UB Gateway S-Miles To Go Dental Program

PATIENT INFORMATION			DATE:		
Child's Name:		Sex: M / F		Birth Date: / /	
Address:		City:		Zip Code:	
Phone:		Child's Social Security Number:			
Child's School:		Teacher's Name:			
Race/Ethnicity: (Circle One) Caucasian African American Asian Hispanic Other:					
PARENT OR GUARDIAN INFORMATION					
Parent/Guardian Name:		Sex: M / F		Birth Date: / /	
Address:		City:		Zip Code:	
Social Security Number:		Home Phone:			
Work Phone:		Cell Phone:			
Language Spoken at Home:					
TYPE OF DENTAL COVERAGE (PLEASE CHECK ONE,YOUR INSURANCE WILL BE BILLED)					
☐ NO DENTAL COVERAGE ☐ DENTAL INSURANCE TYPE:			Insurance Example: Medicaid, Fidelis, Healthplex etc.		
PLEASE ENTER ID #			CIN/SEQUENCE #:		
PLEASE PROVIDE THE ABOVE INFORMATION					
HEALTH INFORMATION					
IS YOUR CHILD IN GOOD HEALTH?				☐ Yes	☐ No
If no, explain:					
IS YOUR CHILD TAKING ANY MEDICATIONS?				☐ Yes	☐ No
DOES YOUR CHILD HAVE ANY SPECIAL HEALTH CARE NEEDS Blind Deaf Wheelchair Other: _____				☐ Yes	☐ No
If yes, list medications: NAME OF CHILD'S Medical Doctor:					
IS THIS YOUR CHILD'S FIRST DENTAL VISIT?		☐ Yes		☐ No	☐ Not sure
If no, has it been over 12 months since his/her last visit?				☐ Yes	☐ No
DOES YOUR CHILD HAVE ANY EXISTING DENTAL PROBLEMS/CONCERNS (toothache, loose tooth, swelling?)				☐ Yes	☐ No
If yes, explain:					

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?					
Heart Disease	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Blood Transfusions	☐ Yes	☐ No
Sickle Cell	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No	Prolonged Bleeding	☐ Yes	☐ No
Hepatitis / Liver	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Emotional disorder(s)	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Allergies **	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Other?	☐ Yes	☐ No	Speech or Hearing Impaired?	☐ Yes	☐ No
** Please list known allergies:					
Signature of UB Dentist:				over →	

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CHILD'S PREVIOUS DENTIST IF ANY:

BELOW SELECT ONLY 1 BOX

☐ Yes, I would like my child **to have a dental examination including x-rays (if needed), cleaning, fluoride treatment, sealants and treatment (as described below)** by a licensed dental provider and/or dental student who is supervised by a licensed dental provider. I also grant consent for round trip transportation to the UB School of Dental Medicine.

OR

☐ Yes, I would like my child **to have a dental screening only (no charge to you)** by a licensed dental provider and/or dental student who is supervised by a licensed dental provider. I also grant consent for round trip transportation to the UB School of Dental Medicine.

OR

☐ No, I do not wish to enroll my child.

DENTAL CONSENT FORM: (IT IS NOT NECESSARY TO COME WITH YOUR CHILD TO THE APPOINTMENT)

I understand that by signing this form I am consenting for the child named above to receive a dental examination, bite-wing and/or panoramic x-rays as needed, dental cleaning, brushing / flossing instructions, fluoride treatment, sealants, fillings, crowns, extractions and pulpal therapy as needed**. I also understand my child will be bused from his/her school to the University@Buffalo, School of Dental Medicine located at 3435 Main Street/Squire Hall, Buffalo, NY 14214.**

The risks associated with treatment are: accidental biting or scratching of the lip/cheek by the child if local anesthesia is used and /or slight discomfort, bleeding and /or swelling.

If no treatment is provided, the following may occur: undetected dental/oral disease (cavities, gum disease etc.) which may lead to pain, swelling, and/or infection.

I understand that this consent may stay in effect for one school year while my child attends this school.

I understand that it is my responsibility to inform the dental provider and/or the school nurse of any changes in my child's medical information.

I understand that all information about my child will be kept confidential.

I understand a copy of the dental school's Notice of Privacy Practices is available upon request and will be provided at the child's first visit.

If your child needs specialty care (sedation), you will be notified and will be requested to accompany your child to the UB School of Dental Medicine.

I consent to UB School of Dental Medicine contacting my son/daughter's school and/or Health Related Services, Buffalo Board of Education, to release any medical information needed for my child's treatment

I further consent that my child's medical doctor may release any medical information to Dental Unit staff that may affect his/her dental treatment.

Photographs may be taken for educational purposes. I hereby grant the University at Buffalo School of Dental Medicine permission to use the likeness of my child in a photograph or other digital reproduction in any and all of its publications, including website entries, without payment or any other consideration. If **No, check here** ☐

As parent/guardian, I agree that I am financially responsible for the care provided to this child and understand my dental insurance will be billed. Parents may request an estimate of the cost of treatment prior to treatment. Financial assistance is available by calling 716-803-3699.

_____

PARENT/GUARDIAN SIGNATURE: DATE

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PLEASE NOTE: THIS DOCUMENT AND THE NOTICE OF PRIVACY PRACTICES ARE FOR YOUR INFORMATION ONLY AND SHOULD NOT BE RETURNED.

If you child has a dental emergency Monday thru Friday between the hours of 9am-4pm, please call 716-829-2723. After hours or on the weekend, proceed to your nearest emergency care facility or Woman's and Children's Hospital, 219 Bryant St. Buffalo, NY 14222 (716-878-7000). The UB School of Dental Medicine is not responsible for reimbursement of any charges you incur while obtaining emergency dental care at any other facility.

If you have any questions regarding this program please call Julie Caizza at 716-803-3699.

Your child will be a registered patient of the UB School of Dental Medicine.
The following are your rights and responsibilities as a patient.

YOU HAVE THE RIGHT TO:

1. Understand and use these rights. If for any reason you do not understand or need help, the school will provide assistance.

2. Be treated with dignity and respect, regardless of your race, religion, age, sex, beliefs, lifestyle, national origin, disability, or sexual orientation.

3. Receive confidential treatment in a clean and safe environment, free of unnecessary restraints. Receive continuous care to completion of planned treatment with knowledge of anticipated cost.

4. Receive emergency, incremental and total care consistent with the standard of care in the profession.

5. Receive education, counseling and explanations to your questions.

6. Know the names, positions and functions of any personnel involved with your care.

7. Receive complete information about your diagnosis, treatment and prognosis.

8. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include possible risks and benefits of the procedure or treatment.

9. Refuse examination, treatment or change your mind and be told what effect these actions may have on your health.

10. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

11. Privacy and confidentially of all information and records regarding your treatment.

12. Participate in all decisions about your treatment.

13. Review your records with a clinician and obtain a copy of your record for which the School of Dental Medicine can charge a reasonable fee.

14. Receive an itemized bill and explanation of all charges.

15. Complain without fear of reprisals about the care and services you are receiving.

16. Access to a patient advocate.

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YOU HAVE A RESPONSIBILITY TO:

1. Provide to the best of your knowledge, accurate and complete information about present medical and dental history, past illnesses, hospitalizations, medications, and other matter relating to your health. You have the responsibility to report changes in your health status.

2. Follow the treatment plan agreed upon by you and your dental care providers. This may include following instructions of allied dental health personnel as they carry out the coordinated plan.

3. Make known to your dental care provider that you understand and accept the treatment plan and that you know what is expected of you.

4. Comply with the rules and regulations of the UB School of Dental Medicine, The State University of New York at Buffalo, and the State of New York.

5. Be on time and available for your appointments.

6. Have a working phone number in order for your dental provider to be able to contact you to schedule appointments.

7. Be considerate and respectful of the rights of other patients and UB School of Dental Medicine personnel. You are responsible for being respectful of the property of other persons and the University at Buffalo.

8. Provide proper childcare while you are being treated at the SDM clinics. Children are not to be left unattended and are not permitted to accompany an adult patient who is receiving treatment.

9. Pay for service at the time it is provided.