St. Vincent
MOBILE DENTAL CARE FOR KIDS (812)-485-5843

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

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