NEW THIS YEAR:

Molar Express Services Have Changed

Register today to receive the latest in preventive dental care. We'll provide:

- An overview of your child's dental needs
- Information to connect with a local dentist for an exam, x-rays and fillings if needed
- One-on-one brushing and flossing education with your child
- Ways to prevent cavities and protect your child's teeth

Molar Express will no longer have a dentist visiting the schools. Instead we will connect you with local dentists for continued care.

Molar Express is a portable dental program equipped to provide preventive dental services to students at the school they attend. A Certified Public Health Dental Hygienist may offer screenings, cleanings, fluoride varnish, sealants, decay-stopping fluoride treatment, or temporary fillings.

REGISTRATION FORM

Please keep the top sheet (Notice of Privacy Practices) and return the 2nd page of this form to your school nurse!

A new form must be filled out each school year for each child.

Our contact information:

- Go to our website: www.nchcnh.org (click on the truck)
- Call us at (603) 259-3700 ext 241
- Email us a request molarexpress@nchcnh.org
- Address: Molar Express, 262 Cottage Street, Suite 230, Littleton, NH 03561

We look forward to seeing your child's smile soon!

Is Molar Express for my child?

This program is to help families identify dental/oral health needs, provide evidence-based preventive services to reduce the risk of cavities and provide referrals to dental home for continued care. The preventive services may include screenings, cleanings, fluoride varnish, sealants, decay-stopping fluoride treatment, or temporary fillings.

No insurance? We can help: Fill out the form and one of our team members will reach out to you with options.

Molar Express

Patient's Rights and 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. If you are a parent or personal representative acting on behalf of an unemancipated minor, "you" and "the patient" in the document below refers to the child. **Please review it carefully**.

Uses of Information and How Information is Disclosed

Information given to The Molar Express and its staff may be used for treatment, including for: 1) identifying treatment goals agreed upon by both patient and staff; 2) setting a plan of treatment for pursuing those goals; and 3) monitoring effectiveness of the treatment plan.

Information given to The Molar Express and its staff may be used as The Molar Express and/or its agents seek payment for services, including: 1) mailing invoices to a patient at the address given by the patient; 2) submitting patient information to insurance providers, if the patient requests this, such as social security number, date of birth, address, dental diagnosis, insurance policy number, and dates of service; 3) writing, phoning, or e-mailing the other payer(s), if the patient requests this, and identifying the patient, to seek payment for services; and 4) giving patient information such as social security number, date of birth, address, and dates of service to a collections agency if the patient makes no payment arrangements as per the payment agreement.

Information given to The Molar Express and its staff may be used by The Molar Express and/or its agents for dental care operations, in the sense that staff may make and/or track appointment times and will write in patient chart information about dental diagnosis and treatment services provided. Staff may telephone the patient with appointment reminders and other treatment related information. Information may be used and shared for your treatment and care coordination.

Information will be disclosed generally by providing hand delivered materials in sealed envelopes, via United States mail, talking on the phone, or encrypted email service when disclosure is appropriate. However, with a few exceptions (see below), information about a patient will not be disclosed to anyone outside of The Molar Express without the patient's written authorization. The patient may revoke such authorization at any time; revoking authorization requires two actions by the patient: 1) telling or writing such to staff; and 2) ensuring that their request has been received by staff, by for instance asking staff to state understanding that authorization is revoked.

Without the patient's written authorization, information about a patient will not be disclosed to anyone, with the following exceptions: 1) if staff determines that the patient or someone else is at risk of eminent physical harm; 2) if staff determines that a child, (meaning anyone under 18 years old) might have been or possibly is being physically harmed, neglected or endangered; 3) if staff determines that a senior (meaning anyone 60 years old or older) might have been or possibly is being physically harmed, neglected or endangered; 4) if there is a medical emergency; or 5) if ordered by a judge. In such situations, staff will provide information deemed useful to ensure safety or to abide by applicable law and may take steps to ensure safety, including for example calling police or arranging a hospital visit.

Patient's Rights

The Molar Express patient has the right to: 1) request restrictions on certain uses and disclosures of protected health information, although The Molar Express is not required to agree to the request; 2) receive confidential communications of the patient's protected health information; 3) inspect and copy protected health information; 4) request to amend protected health information; 5) receive an accounting of disclosures of protected health information; and 6) receive a copy of this notice upon request.

Responsibilities of The Molar Express

The Molar Express is required by law to: 1) maintain the privacy of protected health information and to provide patients with notice of this responsibility; and 2) follow the terms of this notice whenever transmitting patient information by computer and 3) offer patients a revised copy of this notice if The Molar Express revises this notice in the future.

Complaints

If you believe your privacy rights have not been upheld, you may inform The Molar Express and its staff at 603 259-3700. The best approach for addressing such complaints would be to discuss it with The Molar Express staff. If after doing this you are not satisfied, you may call the HIPAA Hotline at 866-627-7748 or www.cms.hhs.gov/hipaa.

KEEP THIS PAGE FOR YOUR RECORDS

2018/ 2019 School Year

Molar Express

PATIENT REGISTRATION FORM

Please complete **BOTH SIDES** of this confidential form, **sign the back of this form (2 places) and return** to your child's school.

C H I L D

Child's Name: ______________________________________ School: ________________________________

Nickname: _____________ Grade_____ Date of Birth _____/_____/_____ Age ______ Sex (M) (F)_____

____

(home address) *(town)* *(state)* *(zip code)*

C O N T A C T

Parent/Guardian Name(s)____________________________ Who does child live with? ______________________

(Phone contact information is required so the Dental Team may talk with you about your child.)

Primary Phone # (_____)______-________ *(home / cell / work)* Alternate Phone # (_____)______-________*(home/ cell / work)*

Email address____ Preferred contact through: Phone / Email / Text

Please list names of who we can speak to regarding your child's dental needs/appointments:__________________

____

____ **No, I do not want my child to participate.** My child has a regular dentist and does **NOT** need Molar Express.
If checked, you do not need to fill out this form.

H I S T O R Y

Please list any information you want us to know about your child's dental needs: __________________________

____

Previous Dentist's Name ____

Date child was last seen at dental office: _____/_____/______

Reason seen: ____

____

I N S U R A N C E

Check the appropriate statement regarding your child's dental insurance:

____ Does NOT have any type of Medicaid or Dental Insurance

____ Has Medicaid Insurance. Their insurance number is: *(typically located at the bottom of their card)*

New Hampshire: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Vermont:** ___ ___ ___ ___ ___ ___ ___

____ Has Dental Insurance through a parent *(attach a copy of both sides of the insurance card)*

Insurance Co. Name: ____ Phone: (_____)______-__________

Group #:__________________________________ Policy ___________________________________

Subscriber's Name: _________________________ Subscriber's Date Of Birth: ____/____/_____

OVER: PLEASE FILL OUT AND SIGN OTHER SIDE

OFFICE USE ONLY:

____

____

CHILD'S MEDICAL HISTORY

Regular Doctor's Name ___________________________________ Doctor's Phone # (_____)______-___________

Does your child have a congenital heart defect or any other condition requiring pre-medication with antibiotics before dental treatment? _____Yes _____ No

Does your child have any allergies? _____Yes _____ No
If yes, please explain ____

Has your child had any serious health problems? _____Yes _____ No
If yes, please explain ____

Please list all siblings:

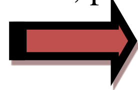
1. Name: ________________________________ Age: _____ School: __________________________________
2. Name: ________________________________ Age: _____ School: __________________________________
3. Name: ________________________________ Age: _____ School: __________________________________
4. Name: ________________________________ Age: _____ School: __________________________________

Do you have any other information you want us to know about your child?___________________________________

Permission & Privacy Practices

* * * PLEASE READ THIS SECTION AND SIGN **BOTH** LINES BELOW * * *

I give permission for my child to be considered for the Molar Express program and, if accepted, to receive dental care. Dental care may include screening or cleaning teeth, topical fluoride treatments, sealants, temporary fillings, or topical medicine to stop tooth decay (Silver Diamine Fluoride). If you have any questions, please feel free to call us at 259-3700 ext. 241



SIGN HERE____ ___________

(Signature of Parent/Guardian giving permission to treat your child) Date

I acknowledge that I received a copy of The Molar Express Notice of Privacy Practices *(attached sheet)*.

SIGN HERE____ ___________

(Signature of Parent/Guardian for receipt of Privacy Practices) Date

Please return this confidential form to your child's school.