Kids' Mobile Dental Van

How it Works

1. Please fill out forms COMPLETELY. USE INK ONLY. Return it to your child's school.
2. If you do not need to be present, we will call your child from class to complete a dental exam with X-rays. If you do want to be present, we will call to schedule.
3. A letter detailing your child's examination results and necessary treatment will be sent home.
4. Treatment will be completed during school hours.
5. In 6 months, call the Burre or Fortuna Dental Clinic for your child's next check-up.

Our Services

- Comprehensive Exam
- Cleanings
- Sealants
- White Fillings Stainless
- Steel Crowns
- Extractions
- Oral Health Education

opendoor Community Health Centers

Contact us at: (707) 407-7713

We accept Meds-Cal/Partnership, all private insurances, and work with those without insurance. No child will be turned away due to inability to pay.

Open Door Community Health Centers Mobile Dental Program

Consent to Treatment, Payment, and Release of Information

Print Name of Child _____ Child's Date of Birth _____

What dental care do you want your child to receive?
Check the box next to each service you want for your child.

- ☐ **Dental exam**: Includes dental X-rays.
- ☐ **Preventive services**: Includes cleaning, fluoride treatment, sealants, and oral health education.
- ☐ **Treatment of cavities:** Includes fillings, crowns, pulp/nerve treatments. *Local anesthesia may be used.*
- ☐ **Extraction of baby tooth:** *Local anesthesia may be used.* If needed, one dose of children's ibuprofen may be given. We call the day before to inform you.

Note: Extraction of permanent tooth requires an additional consent

Which appointments would you like to be present for? It will take place during school hours. Please note that there is limited room on the van and you may need to wait outside nearby.
Check the box next to each service you would like to be present for.

- ☐ I do NOT need to be present for appointments.
- ☐ I want to be present for the exam.
- ☐ I want to be present for preventive services(cleanings and sealants).
- ☐ I want to be present for fillings.
- ☐ I want to be present for extractions.

Payment
If my child has dental insurance or Medi-Cal/Partnership, I agree to present their current coverage card.
No child will be turned away, regardless of your ability to pay.

Additional Consents Please use the QR code to access.
Also available at https://opendoorhealth.com/locations/burre-dental-center/mobile-dental-van/
I agree that the following consents have been made available for my review and I agree to the terms included in these documents.

- Open Door's Notice of Privacy Practices
- Dental Material Fact Sheet
- ☐ I cannot access forms electronically and request a paper copy.

By signing below, I agree:

- I have read this consent, or had this consent read to me.
- I understand and consent to the above statements.
- I authorize Open Door Mobile Dental Program staff to provide the dental care I chose above.
- The information I provided is true and correct, to the best of my knowledge.
- I have had the opportunity to read the Dental Material Facts Sheet and Open Door's Notice of Privacy Practices.

Print name of consenting adult _____ Signature of consenting adult _____ Date _____

Adult's relationship to child _____ Daytime phone number _____ Call / Text Preference

Open Door Community Health Centers

Mobile Dental Health History

Child's Name: First: _____ Last: _____ Date of Birth: _____ Age: _____

Parent/Guardian Name: First: _____ Last: _____

MEDICAL HISTORY

Child's MRN: _____

Date of Last Medical Exam: _____ Provider Name: _____ Specialists: _____

Has your child had any of the following:

	YES/NO			YES/NO	
Irregular Heartbeat or Blood Pressure	☐	☐	Diabetes (high/low blood sugar)	☐	☐
Congenital Heart Defect or Heart Surgery	☐	☐	Behavioral or Psychiatric Treatment	☐	☐
Artificial Heart Valve	☐	☐	ADD/ADHD	☐	☐
Blood Disorders (anemia, sickle cell)	☐	☐	Autism Spectrum Disorder	☐	☐
Hemophilia or Excessive Bleeding	☐	☐	Developmental or Intellectual Disability	☐	☐
Cancer/Radiation/Chemotherapy	☐	☐	Impaired Vision, Hearing, or Speech	☐	☐
Liver or Kidney Problems	☐	☐	Frequent Sinus or Tonsil Infections	☐	☐
Thyroid Disease	☐	☐	Asthma or Breathing Problems	☐	☐
Seizures/Epilepsy	☐	☐			

Has your child ever been hospitalized? If yes, for what?

_____

_____

Any other problems or conditions not listed?

_____

_____

MEDICATIONS (include prescriptions, over-the-counter medications and inhalers)

_____

_____

☐ Check here if none (use back side for additional space)

ALLERGIES

_____

_____

☐ Check here if none

Date of Last Dental Exam: _____ Dentist/Clinic: _____

- Does an adult help with brushing and flossing? Yes / No
- Has the child had any unpleasant experiences in the dental or medical office? Yes / No
- Has the child had any injuries to the face, mouth, or teeth? Yes / No
- Does the child have any oral habits (thumb sucking, biting fingernails, etc.)? Yes / No
- Has the child complained of tooth pain? Yes / No

Any specific questions or concerns?

_____

Please notify us if changes occur. Appointments may be rescheduled if the child is sick or struggling to breathe through their nose.

Parent/Guardian Signature: _____ **Date:** _____

OPEN DOOR COMMUNITY HEALTH CENTERS **PATIENT INFORMATION**

Legal Last Name:_____ **Legal First Name:** _____ MI: _____

Preferred Name: _____ **Pronouns:**_____

Other Names you may have used: _____

Social Security Number: _____ **Date of Birth:** _____

Address (Mailing): _____ **City:** _____ **Zip Code:** _____

Telephone: _____ **May we contact you at home?** ☐ Yes ☐ No

Other Contact: ☐ Cell Phone ☐ Work Phone ☐ Message Phone _____

Legal Sex: ☐ Male ☐ Female ☐ X

Gender: ☐ Male ☐ Female ☐ Trans Male ☐ Trans Female ☐ Other ☐ Nonbinary / Genderqueer ☐ Questioning ☐ Choose not to disclose

Ethnicity: ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Latino/a and/or Spanish Origin ☐ Non-Hispanic or Latino/a ☐ Unknown

Race: ☐ White ☐ Asian Indian ☐ American Indian ☐ African American ☐ Chinese ☐ Alaskan Native ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan ☐ Native Hawaiian ☐ Unknown

Preferred Communication: ☐ No preference ☐ Mail ☐ Phone ☐ MyChart

Veteran Status: ☐ Yes ☐ No

Emergency Contact Information (for patient, or for responsible party if patient is a minor):

Emergency Contact Name: _____ **Phone #:**_____

Relationship to Patient: ☐ Spouse ☐ Mother ☐ Father ☐ Grandparent ☐ Other: _____

Are Interpreter Services Needed? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other: _____

Mother's Maiden Name:_____

Guarantor Information (The person responsible for payment, example: a parent for a patient under 18 years of age)

Last Name: _____ **First Name:** _____ **MI:** _____

Billing Address: ☐ same as above_____ **City/Zip:** _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Other: _____

Social Security Number: _____ **Legal Sex:** ☐ Male ☐ Female ☐ X

Date of Birth: _____ **Telephone:** _____

Insurance Name: _____

Insurance ID Number:_____ **Issue Date:** _____

Where do you currently live?: ☐ In my home or apartment ☐ At a shelter ☐ Staying with others ☐ In transitional housing ☐ The street, a camp, under a bridge, or in a car

Migrant Status: ☐ Migrant ☐ Seasonal ☐ Neither

Office Use Only: Entered by:_____ Date: _____ MRN#: _____

Housing and Income Information

Sliding Fee Discount Program

opendoor Community Health Centers

Why we ask for this information

Open Door Community Health Centers receive grants and federal funding to support our services. Each year we must collect information about the communities we serve to share with our funders. By completing this form, you are helping us keep our funding so we can offer more services.

We combine your information with others and report it in summary form. We do not share any personal information or report data that could be used to identify you.

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1. Information about you and where you live

Name	**Birth date**	**MRN** *Office Use*

Are you a veteran? (Check one) ☐ Yes ☐ No

How do you describe where you live? (Check one)

- ☐ Live in a place I own or rent (house, apartment, condo, or townhouse)
- ☐ Live in someone else's place on a temporary basis ("couch surfing")
- ☐ Live in transitional housing (Arcata House or halfway house)
- ☐ Live somewhere as part of a program or treatment (hospital, hotel or motel, respite care, treatment program, jail)
- ☐ Live in emergency shelter
- ☐ Live unsheltered (in a tent, car, around buildings or bridges)

At any time in the last 12 months were you without a regular place to live? (Check one) ☐ Yes ☐ No

2. Information about the people in your household

Please list the names and birth dates of the people in your household. Your household includes people you live and share an income with.

Name	**Birth date**	**MRN** *Office Use*

3. Information about household income

What is your household income before taxes or deductions? This is the total amount earned by all members of your household, including you.

Examples of income (check all that apply):

- ☐ Wages or salary from employment or self-employment
- ☐ Other earnings from employment, such as tips or commissions
- ☐ Child Support
- ☐ Spousal Support
- ☐ Any other source of income_____
- ☐ Alimony
- ☐ Pension or Retirement income
- ☐ Social Security
- ☐ Disability payments
- ☐ Unemployment payments

Total household income: $_____

Is this income (Check one) ☐ Weekly ☐ Monthly ☐ Annually

4. Eligibility for sliding fee discount scale co-payment

Based on your household income reported above you may be eligible for a discount on the fees for your services.

If you are reporting no income above, you must describe your current means of support and/or living situation:

_____

We reserve the right to request evidence of your income in the form of pay stubs, tax returns, or other documents in order to qualify for discounts.

5. Certification and signature

I declare that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services.

Signature:_____ Date:_____

OFFICE USE ONLY SITE_____ Calculated Annual Income_____

Income Verified*: ☐ Yes (Expires 365 days) ☐ No (≤200% FPL-Expires 30days) ☐ No (>200% FPL- Expires 365days)

Notified Patient about eligibility screening and application assistance through Open Door Member Services: ☐ Yes

This applicant is: ☐ Eligible for Discount of: ☐ A Scale ☐ B Scale ☐ C Scale ☐ D Scale ☐ $0 Co-pay**
☐ Not Eligible for Sliding Scale Discount ☐Patient Declined

**$0 co-pay requires re-certification by Office Manager at each visit and cannot be applied to family members.

Termination date:_____ Certified by: Signature:_____ Date:_____

Document eligibility for each family member for each account type within registration.
Enter date eligibility begins (the certification date on this sheet) for each eligible account.
Scan form into Documents under FDS – Financial Document, DESC – FPL.

*ROUTE TO MEMBER SERVICES for follow-up assistance: 1) any form for patient eligible for SFS≤200% and not yet verified; and/or 2) any form for patient with no primary coverage (or no coverage other than SFS)

Open Door's Member Services Referral Form

ASSISTANCE IS FREE!

Humboldt:
Phone: (707) 269-7073
Fax: (707)269-7045

Del Norte:
Phone: (707) 465-1988
Fax: (707) 465-1987

Member Services can help with:

- Applications for Health Care Benefits or Coverage
- Food resource assistance
- Health care access questions
- *And More!*

Name
Date of Birth:
Name of Parent/Guardian (if applicable)
Daytime Phone:
Email:
Address:

Referred From:
- ☐ Mobile Dental
- ☐ Open Door site:
- ☐ Other: