Kindergarten Dental Permission Form

(All other grades will need to complete and sign a different permission form.)

California law (Ed Code 49452.8) states your child must have a dental screening their first year in public school. We are offering complete dental care or screening to all Kindergarten students. Your child will be seen, in-school, by a California licensed dental professional. Your options are listed below:

1. COMPLETE DENTAL CARE – RECOMMENDED

If you would like the in-school dentist to provide your child complete dental care including exam, cleaning, fluoride, sealants and x-rays as needed, as well as other dental work as needed, including fillings, **PLEASE COMPLETE AND SIGN THE ATTACHED FORM**. Return the completed form to your school. **THERE IS NO COST TO YOU.***

IMPORTANT: TURN OVER AND COMPLETE FORM

2. DENTAL SCREENING ONLY

If you only want your child to receive a basic dental screening, **no further action is needed**.

IMPORTANT — The results of your child's dental screening will be shared with the school nurse/ healthcare coordinator.

3. NO DENTAL SCREENING

If you **DO NOT** want your child to be seen by a dental professional for a dental screening, please fill out the bottom portion of this letter and return it to your child's school. **Only sign below and return this page if you DO NOT want your child to receive a free dental screening**.

☐ I **DO NOT** wish to have my child participate in the free dental screening being offered at school.

Student's Name: _____

School: _____

Parent/Guardian Signature: _____

Date: _____

If you have any questions, please feel free to call us at 855-481-8639.

*** For patients covered by Medi-Cal (also known as Medi-Cal Dental (Denti-Cal) or Medicaid)**

Big Smiles®

THE DENTIST IS COMING TO SCHOOL!

Get in-school dental care at NO COST* to you.

* For patients covered by Medi-Cal (also known as Medi-Cal Dental (Denti-Cal) or Medicaid)

Sign Up Online!
www.MySchoolDentist.com
Scan the code with your phone.

SIGN AND RETURN TO YOUR SCHOOL TODAY!

Member ADA American Dental Association®

PLEASE COMPLETE

Child's Legal FIRST Name	Child's Legal LAST Name(s)	Birth Date mm/dd/yyyy	☐ Male ☐ Female
Address	City	State	Zip
School	Teacher		Grade
Parent/Guardian Name		Phone ( )	
Email		Alt Phone ( )	
Emergency Contact Name (if different from above)	Phone ( )	Relation to Child	

IMPORTANT HEALTH QUESTION

DOES YOUR CHILD HAVE ANY PAST OR PRESENT MEDICAL CONDITIONS, DISABILITIES, BEHAVIOR OR OTHER PROBLEMS? PLEASE CHECK EACH CONDITION THAT APPLIES TO YOUR CHILD AND EXPLAIN IN THE SPACE PROVIDED. ATTACH ADDITIONAL INFORMATION TO THIS FORM AS NEEDED. IF NO CONDITIONS APPLY, LEAVE BLANK.

☐ Active contagious diseases (including COVID-19)	☐ Allergies-foods/seasonal	☐ Bleeding disorders	☐ Diabetes	☐ Kidney disease
☐ Asthma	☐ Allergies-medications	☐ Breathing problems	☐ Heart problems	☐ Liver disease
☐ Other _____	☐ Behavior problems	☐ Dental problems	☐ Immune disorders	☐ Seizures

Explain _____

List current medications and/or dental concerns: _____

FOLD

FOLD

IF CHILD HAS MEDI-CAL (also known as Medi-Cal Dental (Denti-Cal) or Medicaid)

IMPORTANT: IF YOU HAVE MEDI-CAL, WE MUST HAVE YOUR ID NO. IN ORDER FOR THE DENTIST TO SEE YOUR CHILD.

Circle one of the following: Medi-Cal Dental, Health Net, Liberty, California Dental Network, Health Plan of San Mateo, Health Plan of San Joaquin

Enter Child's BIC ID Number HERE: → **ID No.** 9 _____

OR Child's Social Security # (if available) ___ ___ ___ – ___ ___ – ___ ___ ___ ___

PRIVATE DENTAL INSURANCE

Ins. Company Name (*not Medicaid*) _____ Ins. Phone ( ) –

Group # Employer Name Co. Phone ( ) –

Insured Adult Name **Insured Adult Birthdate** / /

Member ID/Policy # Insured Adult SS # – –

IF CHILD HAS NO DENTAL INSURANCE

☐ I may be interested in paying for dental services. Please contact me.

If your child sees a dentist regularly, and you want to continue care with that dentist please do so.

READ & SIGN BELOW (If you have questions or would like to speak to a dentist, please call us at 855-481-8639.)

I understand and authorize Marn DDS Dental Practice P.C. (Provider), its affiliated dentists and dental hygienists, and externs from UCLA and UCSF Schools of Dentistry under dentist supervision, to provide dental services at school to the above named child for whom I am the custodial parent or legal guardian. Dental services include an exam, cleaning, fluoride, sealants, Preventive Resin Restoration, x-rays and the application of Silver Diamine Fluoride as needed. (The use of Silver Diamine Fluoride may discolor any cavities to a brown or black color. SEE BACK FOR DETAILS.) I also authorize any other dental work such as fillings, extractions of problem baby teeth, performing a pulpotomy (baby tooth nerve treatment), numbing the mouth and teeth, and other procedures as needed. I have read the IMPORTANT HEALTH QUESTION above and will report any significant changes in my child's health to 855-481-8639. I have read the IMPORTANT NOTICE AND CONSENT ON THE BACK OF THIS PAGE and understand and agree to its terms.

SIGN & DATE HERE _____ _____

This consent authorizes the initial and future dental visits. **DATE**

For your privacy, please fold & secure.

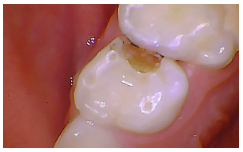
QUESTIONS: 855-481-8639 **FAX: 888-330-4331** **Visit us at BigSmilesDental.org**

Marn DDS Dental Practice P.C.
3201 Wilshire Blvd., Suite 110, Santa Monica, CA 90403

IMPORTANT NOTICE & CONSENT

I understand and authorize Marn DDS Dental Practice P.C. (Provider), its affiliated dentists and dental hygienists, and externs from UCLA and UCSF Schools of Dentistry under dentist supervision, to provide the following services to the named child for whom I am the custodial parent or legal guardian: dental exam & oral hygiene instruction, teeth cleaning, fluoride treatment, digital x-rays (patient will be exposed to a minimal dose of radiation), dental sealants (a thin layer of resin bonded to the enamel grooves of molars to protect them from tooth decay), Preventive Resin Restoration (PRR - removal of minor decay in the enamel grooves and the placement of a composite sealant), as well as the application of Silver Diamine Fluoride to treat the progression of tooth decay. I authorize the dentist, or UCLA/UCSF School of Dentistry Externs under supervision, to fill any cavities or to place a crown over the tooth, extract any problem baby teeth, perform a pulpotomy (baby tooth nerve treatment), place space maintainers or perform other dental treatments as needed. I understand that there are risks to dental treatment including swelling or pain that may occur from the treatment or injection of a local anesthetic, or allergic reaction. (For additional information regarding the risks of treatment and treatment alternatives, please call the number provided.) I understand that a portion of my child's dental examination may be performed remotely and that clinical information (such as x-rays) may be collected and sent electronically to another site for the dentist's evaluation. I consent to these teledentistry services and understand that while confidentiality protections apply, the use of third party electronic transmissions may present additional privacy risks. I understand that I have the right to access medical information related to teledentistry services. I authorize & direct Provider to bill & collect payment from any Medicaid, insurance, or other payer. I authorize my child's school to make available to Provider and its billing agent my child's Denti-Cal number in order to bill payer for services. Further, I authorize the release of my child's Denti-Cal number by Provider or its billing agent to Denti-Cal. If I have private dental insurance, I will be billed for & agree to pay any deductibles and/or co-pays. Unless I have made pre-arrangements to attend, and am there at the time of service, services will be provided without my presence. I consent to the Provider sending text messages about the school dental program. I acknowledge that text messaging is not a secure form of communication and presents additional privacy risks. (Message and/or data fees may be charged by your wireless service provider; to discontinue, simply reply "STOP" to any message received from us. You also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the land-line and/or mobile telephone numbers provided on this consent form.) I have received the Notice of Privacy Practices (NPP) attached to this form and consent to the release of my child's medical record information, including records obtained from other providers, and any HIV/AIDS, communicable disease, sexually transmitted disease, drug and alcohol, and anemia information. I authorize release of such information by Provider to any responsible payor and/or administrative service provider and their subcontractors for use and disclosure relating to my child's treatment, payment for services and health care operation purposes. This signed consent authorizes my child's initial and future dental visits. I may withdraw this consent at any time in writing.

Silver Diamine Fluoride (SDF) - A new dental treatment to fight cavities



Cavity

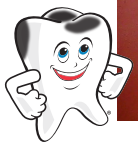
BENEFITS OF SDF: Dental cavities are common in children, but now our dentists have a safe, painless alternative to traditional cavity drilling procedures called silver diamine fluoride (SDF). SDF is an FDA-approved antibiotic liquid used to help prevent cavities from forming, growing, or spreading to other teeth. The dentist simply brushes SDF on back teeth only.

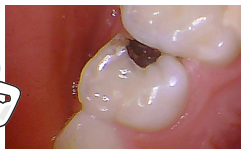
Alternatives

- No treatment: The tooth may continue to decay and cause pain.
- Other options: fluoride varnish, a filling or crown, or extraction of the tooth.

Risks

- SDF treatment may not eliminate the need for a traditional filling.
- It's normal for SDF to stain the cavity brown or black–it means it's working.
- The healthy parts of the tooth will not be stained.
- SDF can cause temporary staining if it comes into contact with skin. The stain is harmless and should disappear in less than a week.
- SDF may cause a temporary metallic taste.





SDF applied

Questions? Call one of our care coordinators at 855-481-8639.

KEEP FOR YOUR RECORDS

MARN DDS DENTAL PRACTICE P.C.

Mandana Akbarian-Boroojeni, DMD, Anderson Alas, DDS, Katrina Angeles, DDS, James Bell, DMD, Marianela Carter, DDS, Ashley Chan, DDS, Ricardo Delgado, DDS, Kourosh Dianatyadzi, DDS, Karen Eisenhofer, DDS, Lorie Espejo, DDS, Theresa Herrera, DDS, Leland Jung, DDS, Rishma Khurana, DMD, Maria Kidwell, DDS, Bum Kim, DDS, Bonnie Krystal, DDS, Mikako Kuga, DDS, Kyoung Lee, DDS, Kenneth Lu, DDS, Daniella Maldonado, DDS, Afrooz Moghadam, DDS, Carolina Moura, DMD, Michelle Nguyen, DDS, An Nguyen-Wong, DDS, Maria Nunez-Ouji, DDS, Essence Page, DDS, Jaein Park, DDS, Jinhee Park, DDS, Geoffrey Pena, DMD, Pranee Pooudomsak, DDS, Kevin Porres, DDS, Manisha Ramchandani, DDS, Maricarl Ramos, DMD, Antonio Relucio, DDS, Kirk Renshaw, DMD, Ghazal Rokhsar, DDS, Panna Ruparel, DDS, Roger Sandoval, DDS, Jeffrey Shaw, DDS, John Shui, DDS, Alison Simard, DDS, Hector Soria, DDS, Jennifer Wang, DDS, Wan-Jou Renee Wang, DMD, Helen Yeung, DDS, Viacheslav Zoubtsov, DDS

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. PLEASE REVIEW IT CAREFULLY. KEEP FOR YOUR RECORDS

OUR LEGAL DUTY

The privacy of your medical information is important to us. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We will notify you if your unsecured medical information is breached.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician, school nurse/healthcare coordinator, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our business operations such as reviewing the competence or qualifications of healthcare professionals and evaluating practitioner and provider performance.

Your Authorization: Uses or disclosures not otherwise described in this Notice may be made only with your written authorization. In addition, we must obtain your written authorization to sell your medical information or to use or disclose your information for marketing goods or services to you where we are paid to make the communication. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends and Persons Involved in Your Care: We may disclose your health information to a family member, friend or other person involved in your care to the extent necessary to help with your healthcare or with payment for your healthcare. We may also disclose your medical information to disaster relief organizations to help locate individuals during a disaster. We may also use or disclose your medical information to notify, or assist in the notification, of a family member, a personal representative or a person responsible for your care of your location, general condition or death. If you do not want us to disclose your medical information to family members or others in these circumstances, please notify our HIPAA Officer at 888-833-8441.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Safety: We may need to disclose medical information to law enforcement officials, such as in response to a search warrant or a grand jury subpoena, or to assist law enforcement officials in identifying or locating an individual, to report deaths that may have resulted from criminal conduct, and to report criminal conduct on our premises.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, emails or text messages).

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure surveys. These activities are necessary for the government to monitor the health care system, the outbreak of disease, government programs, compliance with civil rights laws and to improve patient outcomes.

Lawsuits and Disputes: We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process.

Other Uses and Disclosures. As permitted or required by law, we may use or disclose your medical information for research purposes; to organizations that handle and monitor organ donation and transplantation; for workers' compensation or similar programs to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness; for public health activities such as to prevent or control disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to, or is at risk for contracting or spreading a disease; to medical examiners to identify a deceased person or determine cause of death; or to funeral directors to carry out their duties.

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information and fax your request to the number at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of some disclosures we or our business associates have made of your health information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we restrict our use or disclosure of your health information. We are not required to agree to your request except when disclosure would be to your health plan, you (or someone on your behalf other than your health plan) has paid in full for your health care, the disclosure relates to payment or health care operations, and the disclosure is not otherwise required by law. If we agree to the restriction, however, we will abide by that agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations specified in your written request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: HIPAA Officer
Phone: 888-833-8441
Fax: 888-330-4331
email: HIPAAOfficer@mobiledentists.com
Effective Date: November 1, 2022