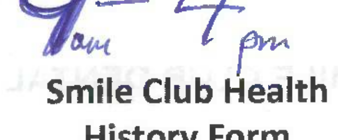
Every Wed. 9am – 4pm



DELTA DENTAL® | DELTA DENTAL OF WISCONSIN FOUNDATION

Smile Club Health History Form

BOYS & GIRLS CLUB

Dental services at the Smile Club are available for **ALL** Boys & Girls Club members.

Your Child's Information:

Date of Birth (MM/DD/YYYY) ____/____/____ Gender: ◯ Male ◯ Female ◯ Other

Child's Name ______________ (LAST) ______________ (FIRST) ______________ (MIDDLE INITIAL)

School Attending ______________ Grade ______

Ethnicity (select one)

◯ Hispanic
◯ Non-Hispanic
◯ Decline to Specify

Race (check all that applies)

◯ White
◯ American Indian/Alaskan Native
◯ Decline to Specify
◯ Asian
◯ Black/African American
◯ Native Hawaiian/Pacific Islander
◯ Other ______

Child's Dental Insurance: ◯ Forward Health/Medicaid/BadgerCare ◯ Private Insurance (Carrier Name: i.e. Delta, Cigna) ◯ None ◯ Member ID number (if known)

Does your child qualify for free or reduced rate meals at school? ◯ Yes ◯ No

Does your child have a dentist? ◯ Yes ◯ No Dentist Name ______ Date of last visit ______

Parent/Guardian Information:

Parent/Guardian's Name ______________ Preferred Language ______

Address ______________ City/Zip ______________

Phone ______ (HOME) ______ (CELL) Email ______________

Emergency Contact ______ (NAME) ______ (PHONE) ______ (RELATIONSHIP TO PATIENT)

Has your child had any history of or conditions related to any of the following (Check all that apply):

◯ Anemia/Sickle Cell	◯ Cancer	◯ Hearing Impaired	◯ Kidney Disease	◯ Other serious illness or operations ______
◯ Arthritis	◯ Cerebral Palsy	◯ Heart Condition	◯ Liver Disease	
◯ Asthma/Breathing Issues	◯ Diabetes	◯ Hepatitis	◯ Rheumatic Fever	
	◯ Down Syndrome	◯ Herpes	◯ Tuberculosis	
◯ Autism	◯ Epilepsy or Seizures	◯ High Blood Pressure	◯ Sexually transmitted infection	
◯ Bleeding disorder	◯ Fainting/Dizziness	◯ HIV/AIDS		

Does your child have any allergies/drug allergies? (i.e. Amoxicillin, Penicillin, etc.)	Is your child taking any medications?	Does your child need pre-medication for a dentist appointment? (Prescribed by Dr.)	Medical Physician:
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	Name(s): ______
Please List: ______	Please List: ______	Please List: ______	

I understand that, except for in circumstances where the dentist determines, further immediate treatment is necessary to address pain or infection issues or for other reason that in the judgment of the dentist required immediate treatment, the patient's initial visit will consist of X-rays, diagnostic evaluation, and preventative services (cleaning, fluoride varnish and sealants).

Smile Club does not offer all dental services or specialty care.

SMILE CLUB DENTAL CARE CONSENT FORM

Having read the privacy information attached to this form, and having accurately filled out the medical history information, I hereby consent to ______________________________ (patient's name) participation in the preventive and restorative dentistry program to be conducted by Delta Dental of Wisconsin Foundation (Foundation) staff and volunteers. If the patient has ForwardHealth (BadgerCare) coverage, I authorize ForwardHealth to be billed for billable services.

I understand that in order to provide effective, safe care, my child's privately protected health information may be shared between the Boys & Girls Club, volunteer and paid dental providers, referring dental offices and the Delta Dental of Wisconsin Foundation (Smile Club).

I understand that prior to any additional treatment, a consent form will be delivered to me and that I will be required to come to the Boys & Girls Club or another dental office for the purpose of receiving an explanation of the procedures that may be undertaken by the dentist before those services are delivered.

I understand that if the patient becomes uncooperative during dental procedures with movement of head, arms and/or legs, to the degree that dental treatment cannot be *safely* provided, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements at the direction of the dentist.

In consideration of the dental services to be provided and upon notice as explained in this form, I for myself and the patient and anyone entitled to claim through me or the patient, do hereby waive and release the Delta Dental of Wisconsin Foundation, Boys & Girls Club, paid and volunteered dentists, dental hygienists, dental assistants or any other persons or organizations operating on behalf of the Smile Club or its agents or volunteering services in this program from any and all liability arising from my acceptance of such care, including but not limited to, medical, surgical, dental, or other health care advice, so long as such care is delivered in a manner consistent with reasonably accepted medical/ dental services and this agreement.

I have read the foregoing and have had an opportunity to have all my questions answered. In the event that I have any additional questions, I understand that I can get my questions answered prior to executing this form by contacting the Smile Club at **715-204-1180**.

I understand that the health information provided herein and this consent can be used for 12 months and if any change occurs in the patient's health status or if I wish to revoke the consent, I must notify Smile Club by calling **715-204-1180**. I understand that if my child's health information is released according to the authorization above, it may be subject to re-disclosure by a person who receives the information and may not be protected by law.

I agree to seek any follow-up care my child may need from a local dentist, physician or emergency room.

I hereby acknowledge and attest that I have the legal authority to consent and authorize to the provision of medical and dental services to patient in the best interests of the patient as stated in this document.

PLEASE PRINT, SIGN & INITIAL BELOW

____

PRINT NAME OF PARENT/LEGAL GUARDIAN/PATIENT

____

SIGNATURE DATE

Return form to: Boys & Girls Club, Attn. Smile Club, 941 Michigan Ave., Stevens Point, WI 54494

DELTA DENTAL OF WISCONSIN FOUNDATION, INC.
SMILE CLUB
NOTICE OF PRIVACY PRACTICES AND RIGHTS

This Notice of Privacy Practices and Rights ("Privacy Notice") is required by the Health Insurance Portability and Accountability Act ("HIPAA") and federal regulations (together the "Privacy Rule") and describes how personal health information about you may be used and disclosed by Delta Dental of Wisconsin Foundation, Inc. Smile Club ("DDWIF") and how you can get access to this information.

PLEASE REVIEW THIS NOTICE CAREFULLY

The privacy practices described in this Privacy Notice are in effect as of March 7, 2022 and will remain in effect unless modified by DDWIF. DDWIF reserves the right to change its privacy practices and the terms of this Privacy Notice at any time as long as the changes comply with the law. If we make changes, a new Privacy Notice will be displayed in our office and provided to patients. You may request a copy of our Privacy Notice at any time.

OUR USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

DDWIF may use and disclose your protected health information without your written consent or authorization for treatment, payment and healthcare operations.

- **Treatment:** We may use and disclose your health information to all of our staff members, other dentists, your physicians, and/or other health care providers taking care of you. For example, DDWIF may determine that you need additional dental treatment from another provider. In referring you to another provider, DDWIF may share or transfer your health information to that provider.

- **Payment:** We may use or disclose your health information to obtain payment for services we provide to you and to participate in quality assurance, disease management, training, licensing and certification programs. For example, DDWIF will submit claims to the Wisconsin Medicaid program or to an insurer on your behalf. The claim will identify you and the dental services provided.

- **Healthcare operations:** We may contact health care providers and patients with information about treatment alternatives, conduct quality assessment and improvement activities, conduct outcomes evaluation and development of clinical guidelines, develop protocols, coordinate case management or care and conduct or arrange for medical review, legal services and auditing functions. For example, DDWIF may use your treatment and outcome information to measure the quality of the services that it provides or to assess the effectiveness of your treatment when compared to patients in similar situations.

DDWIF also has the right to use and disclose your protected health information without your written consent or authorization as follows:

- **To your family and friends:** We must disclose your health information to you, as described in the "Your Rights" section of this Privacy Notice. If you are a minor, we may disclose your protected health information to a parent or guardian without your consent. If you are not a minor, we will need your written authorization to disclosure your health information to family members, other relatives, close personal friends or any other person.

- **As permitted or required by law:** When we are required to report individual health information to legal authorities, court officials or governmental agents. For example, we may be required to report abuse, neglect, domestic violence or certain physical injuries.

- **For public health activities and to avoid serious threat to health or safety:** We may use or disclose your health information to prevent or control disease, injury or disability and to report reactions with medications or problems with products, to notify people of recalls of products they may be using and to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease or conditions.

- **To notify of suspected abuse or neglect:** We may use or disclose your health information to notify the proper government authority if we believe a patient has been the victim of abuse, neglect or domestic violence (when required by law).

- **For health oversight activities:** We may use and disclose health information in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification.

- **When legally required to disclose:** Patient healthcare records, including treatment records, may be disclosed pursuant to a lawful court order or as otherwise required by law.

- **For national security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

- **For research:** Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- **For workers' compensation:** We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

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

- **Sign-in sheet and announcement:** Upon arriving at the place where Smile Club services will be provided, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

- **To business associates:** Some services in our organization are provided through contacts with business associates. Examples may include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.

- **Other authorizations:** In addition to our use of your health information for treatment, payment and healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it 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 Privacy Notice.

- **Marketing health-related services:** DDWIF may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. DDWIF will not otherwise use or disclose your health information for marketing or fundraising purposes without your written consent. In addition, we will not sell your health information.

YOUR RIGHTS

Under the Privacy Rule, you have the following rights:

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request us to provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information.

  We will charge you a reasonable cost-based fee for expenses such as copies. If you request x-rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available by contacting us.

- **Accounting of Disclosures:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years. If you request

this accounting more than once in a twelve-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 place additional restrictions on our use or disclosure of your health information. In some instances, we may not be required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
- **Alternative communication:** You have the right to request that we communicate with you about your health information by alternative means or to an alternative location. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.
- **Amendment:** You have the right to request that we amend your health information. Your request must be in writing and must explain the reason for the amendment. We may deny your request under certain circumstances.
- **Breach notification:** In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.
- **Electronic notice:** If you receive this Privacy Notice on our website or by electronic mail (email), you are entitled to receive a copy in paper form upon request.

QUESTIONS AND COMPLAINTS

If you would like more information about the DDWIF Privacy Policy, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access your health information, to amend or restrict the use or disclosure of your health information, or to request alternative means of communication, you may contact us using the contact information below. You may also submit a written complaint to the Department of Health and Human Services ("HHS"). We will provide you with the HHS address upon request.

DDWIF Smile Club supports your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with HHS.

Shannon Klingforth, dental hygiene and education outreach coordinator
Delta Dental of Wisconsin Foundation
PO Box 828
Stevens Point WI 54481
SKlingforth@deltadentalwi.com
715.204.1180