Family Healthcare of Hagerstown
201 S. Cleveland Avenue
Hagerstown, MD 21740
301.745.3777
www.familyhch.org

Dear Parent:

For over eight years, the *Healthy Smiles in Motion* mobile dental program has provided dental care to thousands of children at many public schools and other community sites. This year we are pleased to continue offering care at public schools during the school year and summer programs throughout the summer months.

Healthy Smiles in Motion is operated by Family Healthcare of Hagerstown as a service to families of Washington County. It helps working parents reduce time off from their jobs by taking dental services to their children. Licensed dentists and dental hygienists provide quality, full-scale dental care to children. We accept most dental insurance plans, including CareFirst BlueCross/BlueShield, Delta Dental, Maryland Healthy Smiles, UnitedHealthcare, and many commercial plans. A sliding fee scale is also available based on family income and Federal Poverty Guidelines.

Look familiar? The Healthy Smiles in Motion mobile dental RV will be near you!

If your family already has a dentist, and you do not wish to have your child seen on the mobile dental RV, please discard this information. To have your child seen by Healthy Smiles in Motion, please complete the attached forms and return them to your child's school. During summer months, these forms should be returned to the program in which your child is attending. Adults are welcome to be seen during the summer and paperwork must be completed as well. Please note that these forms need to be completed every year.

Healthy Smiles in Motion provides all the services of a regular dental office:

- Dental Exams
- X-Rays
- Fillings
- Dental Cleanings
- Extractions
- Oral health education
- Dental Sealants
- Fluoride Treatments
- Root canal therapy (Children Only)

Family Healthcare offers medical care, dental care, and integrated mental health services plus lab services and a pharmacy - all under one roof at 201 S. Cleveland Avenue in Hagerstown.

NEW PATIENTS ARE ALWAYS WELCOME!

FAMILY HEALTHCARE OF HAGERSTOWN

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____ Family Practice
____ Wells House
____ Dental Practice/Mobile
School Child Attends: _____

GENERAL PATIENT INFORMATION

Last Name	First Name		Middle Name
Social Security Number	Date of Birth (mm/dd/yyyy)	Gender at birth ❑ Male ❑ Female ❑Undifferentiated	Who is your Medical Provider?
Home Address:	City	State	Zip
Mailing Address:	City	State	Zip
Email Address:		Are you transgender? ❑ Yes ❑ No If Yes: ❑ Trans-Male to Female or ❑ Trans-Female to Male	
Cell Phone:	Home Phone:	What is your marital status? (Check one) ❑Single ❑Married ❑Divorced ❑Legally Separated ❑Widowed ❑Domestic Partner ❑Annulled ❑Interlocutory ❑Polygamous ❑Unknown	
Student? ❑Full time ❑Part Time ❑Not a student	Smoker? ❑Yes ❑No		
Do You Work? ❑Yes ❑No	If yes, Who Is Your Employer?	What Is Your Occupation?	
Please select one: ❑Asian ❑Native Hawaiian ❑Other Pacific Islander ❑Black/African American ❑American Indian/Alaskan Native ❑White ❑More than One Race ❑ Decline to Specify			
Please select one: ❑Not Hispanic/Latino ❑Hispanic/Latino ❑Decline to Specify ❑Unknown/Not Reported			
Preferred language:		Do you need an interpreter? ❑Yes ❑No	

EMERGENCY CONTACTS IF I CANNOT BE REACHED:

Date:	Emergency Contact/Designee: (Spouse, Friend, Legal Guardian, or Parent (if the patient is a minor)	
	Relationship:	Phone number
Date:	Emergency Contact/Designee: (Spouse, Friend, Legal Guardian, or Parent (if the patient is a minor)	
	Relationship:	Phone number:

GUARANTOR/RESPONSIBLE PARTY:

Last Name	First Name		Middle Name
Address:	City	State	Zip
Phone Number:	Relationship to Patient:	Gender: ❑ Male ❑ Female	Date of Birth (mm/dd/yyyy)

MEDICAL INSURANCE INFORMATION:

Name of Insurance Company:		Policy #
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SS#:
Employer:		Group #

DENTAL INSURANCE INFORMATION:

Name of Insurance Company:		Policy #
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SS#:
Employer		Group #

Do you have a provider that you would like to be scheduled with? If so, who? _____

- I authorize Family Healthcare of Hagerstown to release any information relating to my treatment, examination, and/or clinical results to the Emergency Contact(s) above.
- I authorize Family Healthcare of Hagerstown to leave messages on any phone number provided relating to appointment reminders and/or clinical results or information.
- My signature below indicates that all the information provided on this form is true and correct.

_____ _____

Patient/Parent/Legal Guardian Date

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Community Health Center
UDS (Uniform Data System) Information

Date: _____ Patient Name: _____ Date of Birth:_____

In order to continue offering the variety of services that we offer at Family Healthcare of Hagerstown and to continue to receive grant funding, we are required to collect information on every person that receives care. The information is reported as an overall number and is not reported on individual patients:

1) How many people live in your household? _____
   What is the annual income of all family members in your household?_____

2) Have you or anyone in your household done agricultural (farm) work in the last 3 years?
   ❑Yes ❑No

3) If yes, was it migrant farm work in which you traveled from town to town without establishing a permanent residence?
   ❑Yes ❑No

4) If yes, was it seasonal farm work in which you travel and work seasonally and have an established residence in the same area?
   ❑Yes ❑No

5) Are you homeless?
   ❑Yes ❑No

6) If yes, where did you stay/sleep last night?
   ❑Doubled up ❑Shelter
   ❑Street (including a car or other vehicle) ❑Transitional (including hotel/motel)
   ❑Unknown

7) Do you live in public housing?
   ❑Yes ❑No

8) Are you a veteran?
   ❑Yes ❑No

9) What is your occupation or job? _____

Thank you for providing this important information. It will ensure that we are able to provide you with valuable services and programs in the future.

FHH Staff Initials: _____

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Consent Form

Consent to Treat: _____ _____
Patient Name Date of Birth

I consent to the treatment and procedures that may be performed during my appointment. I have the right to make informed decisions about my healthcare, including the refusal of a treatment or procedure. I understand healthcare students may participate in my care.

Consent to Share Medical Record/Personal Health Information:

I understand that my medical record and/or related personal health information may be shared with the different departments of Family Healthcare of Hagerstown and with offices that support my care. This information will be shared only to help in my health care assessment and management. Examples of this might be information related to/from pharmacies, laboratories, and referral specialists.

I understand that at any time during the course of my medical treatment if a referral to a specialist is required, certain laboratory results and/or details from the medical record could be forwarded to the specialist. This will be done solely to assist in my complete evaluation.

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or by completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org.

Confidentiality:

I understand that Family Healthcare of Hagerstown adopts a very strict policy regarding the privacy and confidentiality of my medical information. I have been given information regarding the Notices of Privacy Practices.

Medical Insurance Authorization and Assignment:

I understand all charges are due at the time professional services are rendered. I authorize Family Healthcare of Hagerstown and all its included entities, to furnish information to my insurance carriers concerning my illness and treatments. For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to Walnut Street Community Health Center, Inc., DBA Family Healthcare of Hagerstown. I understand I am responsible for any amount not covered by insurance, to include co-pays and fees.

I understand that Financial Assistance is available to qualifying patients.

Acknowledgment of Patient Guidelines, Rights, and Responsibilities:

I acknowledge that I have received the Patient Information Guidelines and Patients' Rights and Responsibilities and agree to abide by the policies of Family Healthcare of Hagerstown.

Advanced Directives:

An Advance Directive is a form that you complete saying how much medical care you want to receive in the event you are unable to respond.

Do you have an Advanced Directive? ❑Yes❑ No

Who provides day to day care for the patient? ❑ Self/The Patient ❑ Parent ❑ Other

If other, please provide a name and phone number:

_____

Legal Guardian/Healthcare Proxy:

Does the patient have a Legal Guardian or Healthcare Proxy (a person decided by the patient, family, or courts to make healthcare decisions for the patient if the patient is unable to do so)? ❑Yes ❑No

If yes, we must have a copy for our records.

Name: _____ Relationship: _____ Phone: _____

Consent to give permission to administer Nitrous Oxide

The purpose of this Informed Consent is to provide an opportunity for patients, parents, or guardians, to understand and give permission for the use of Nitrous Oxide when provided along with dental treatment.

- Nitrous Oxide is commonly called laughing gas and provides relaxation, although the patient will be awake, fully conscious, aware of surroundings, and able to respond rationally to questions and directions.
- Nitrous Oxide is not required to provide the necessary dental care.
- The purpose of Nitrous Oxide is to make the patient more comfortable to receive the necessary dental care with less pain and/or anxiety.
- Nitrous Oxide has limitations and will be administered by way of inhalation route and risks and absolute success cannot be guaranteed.
- Nitrous Oxide has been fully explained to me, including all risks involved. I have been fully informed that temporary complications may include, but are not exclusive to tingling in the fingers, toes, cheeks, lips, tongue, head, or neck area; heaviness in the thighs and/or legs, followed by a lighter floating feeling; resonation in the voice or presence of a hyper-nasal tone; warm feeling throughout the body, with flushed cheeks; fits of uncontrollable laughter or giddiness; detachment or disassociation from the environment may occur; lightweight or floating sensation with an accompanying "out of body" sensation; sluggishness in motion and slurring and/or repetition of words; feeling of nausea; vomiting; agitation; and/or hallucination. All these complications are temporary.

My signature indicates that I have read the above consent for Nitrous Oxide and give my permission for myself/my child to have this administered, if necessary. I have informed the dentist of my/my child's complete medical history including any recent surgeries or changes in their medical history involving lungs, respiratory, ear infection, or common cold. I have also informed the dentist if I/my child is pregnant. I understand that for all private insurances Nitrous Oxide sedation is not a covered service. I agree that I will be responsible for the fee of $63.00 unless I am on the $40.00 slide through FHH. I agree to pay for this at the time of service.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

FOR HEALTHY SMILES IN MOTION (Dental bus to schools) PATIENTS ONLY. Please initial the following lines:

I agree to allow Family Healthcare of Hagerstown (FHH) to share this consent form and treatment information completed at my child's school with the school's health room.

I agree to allow FHH to take photographs of my child for his/ her dental record.

I agree to allow my child's school of record, per FHH, to share my contact information/ my child's current school location if the information on FHH's most recent registration packet is not up to date.

I understand that this consent and information, in its entirety, will remain in effect as long as the patient continues to receive health care services at Family Healthcare of Hagerstown/ Healthy Smiles in Motion.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____

Printed Name of Patient/Parent/Legal Guardian

_____ _____

Signature of Witness Date

_____

Printed Name of Witness

FAMILY HEALTHCARE OF HAGERSTOWN

DENTAL/HEALTH HISTORY

Family Healthcare of Hagerstown 201 S. Cleveland Avenue
Hagerstown, MD 21740
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Patient Name: _____ Today's Date: _____
Date of Birth: _____ Date of last dental visit: _____
Former dentist: _____ Reason for visit:_____

DENTAL HISTORY FOR ALL DENTAL PATIENTS:

Have you ever had any of the following:

Bad breath	☐ Yes	☐ No		Grinding/ Clenching teeth	☐ Yes	☐ No	
Bleeding/ Swollen/ Tender gums	☐ Yes	☐ No		Loose teeth or broken fillings	☐ Yes	☐ No	
Cigarette, pipe, cigar/ E-cig smoking	☐ Yes	☐ No		Sensitivity to cold/hot/sweets	☐ Yes	☐ No	
Clicking or popping jaw/ Jaw pain	☐ Yes	☐ No		Sensitivity when biting	☐ Yes	☐ No	
Dry mouth	☐ Yes	☐ No					

How often do you floss? Once a day Twice a day Several times a day Never Other
How often do you brush? Once a day Twice a day Several times a day Never Other

HEALTH HISTORY FOR ALL DENTAL PATIENTS:

Physicians Name: _____ Date of last visit: _____

Have you ever had any of the following:

AIDS/HIV	☐ Yes	☐ No		Kidney disease	☐ Yes	☐ No	
Anemia	☐ Yes	☐ No		Learning disorders/behavior issues	☐ Yes	☐ No	
Arthritis/Rheumatism	☐ Yes	☐ No		Liver disease/Cirrhosis/Jaundice	☐ Yes	☐ No	
Artificial heart valves	☐ Yes	☐ No		Low blood pressure	☐ Yes	☐ No	
Artificial joints	☐ Yes	☐ No		Measles/mumps/chicken pox	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No		Nervous problem	☐ Yes	☐ No	
Back problems	☐ Yes	☐ No		Pacemaker	☐ Yes	☐ No	
Bleeding disorders	☐ Yes	☐ No		Physical abuse	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No		Pneumonia	☐ Yes	☐ No	
Chemical dependency	☐ Yes	☐ No		Psychiatric care	☐ Yes	☐ No	
Chemotherapy	☐ Yes	☐ No		Radiation treatment	☐ Yes	☐ No	
Circulatory problems	☐ Yes	☐ No		Respiratory disease	☐ Yes	☐ No	
Congenital heart lesions	☐ Yes	☐ No		Sexually transmitted disease	☐ Yes	☐ No	
Cortisone treatments	☐ Yes	☐ No		Shortness of breath	☐ Yes	☐ No	
Cough, persistent or bloody	☐ Yes	☐ No		Sinus trouble	☐ Yes	☐ No	
Diabetes (type)	☐ Yes	☐ No		Skin rash	☐ Yes	☐ No	
Emphysema	☐ Yes	☐ No		Special diet	☐ Yes	☐ No	
Do you wear contact lenses?	☐ Yes	☐ No		Stroke	☐ Yes	☐ No	
Epilepsy/seizures	☐ Yes	☐ No		Swollen feet or ankles	☐ Yes	☐ No	
Fainting/dizziness	☐ Yes	☐ No		Stomach problems/frequent vomiting	☐ Yes	☐ No	
Frequent colds or ear infections	☐ Yes	☐ No		Thyroid problems	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No		Tonsillitis/frequent strep throat	☐ Yes	☐ No	
Headaches	☐ Yes	☐ No		Transfusions	☐ Yes	☐ No	
Heart conditions/murmur	☐ Yes	☐ No		Tuberculosis	☐ Yes	☐ No	
Hepatitis (type)	☐ Yes	☐ No		Tumor or growth on head or neck	☐ Yes	☐ No	
Herpes	☐ Yes	☐ No		Ulcer	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No		Weight loss	☐ Yes	☐ No	
Immunological problems	☐ Yes	☐ No		Other _____			

Medications

Please list any medications you are currently taking and the reason you are taking it:

Medication	Reason

Have you used a bisphosphonate medication? ☐ Yes ☐ No

(Fosamax, Actonel, Atelvia, Didronel, Boniva, ETC.)

Allergies

Aspirin	☐	Yes	☐	No	Local Anesthetic	☐	Yes	☐	No
Sleeping pills	☐	Yes	☐	No	Penicillin	☐	Yes	☐	No
Codeine	☐	Yes	☐	No	Sulfa	☐	Yes	☐	No
Iodine	☐	Yes	☐	No	Other:_____	☐	Yes	☐	No
Latex	☐	Yes	☐	No					

HEALTH INFORMATION FOR FEMALE DENTAL PATIENTS ONLY:

Are you pregnant?	☐	Yes	☐	No
Are you nursing?	☐	Yes	☐	No
Are you taking birth control pills?	☐	Yes	☐	No

If yes, due date: _____

ADDITIONAL HEALTH INFORMATION FOR DENTAL PATIENTS AGED 10 YEARS OR YOUNGER:

Is this the child's first visit to the dentist?	☐	Yes	☐	No
Has your child had trauma to teeth, mouth, or face?	☐	Yes	☐	Date: _____
Do you have fluoridated water?	☐	Yes	☐	No

Was your child premature?	☐	Yes	☐	No
Was your child born with any birth defects?	☐	Yes	☐	No
Does your child attend special classes or schools?	☐	Yes	☐	No

Has your child ever been hospitalized?	☐	Yes	☐	No

If yes to any of the above, please explain:

_____ _____

Signature of Patient/ Parent or Guardian (if patient is a minor) Date

_____

Printed Name of Patient/ Parent or Guardian (if patient is a minor)

Walnut Street Community Health Center, Inc. does business as Family Healthcare of Hagerstown (FHH). This health center receives funding through Health and Human Services (HHS) and is a grantee under 42 U.S.C. 254b. FHH has Federal Public Health Services (PHS) deemed status related to certain health or health-related claims under 42 U.S.C. 233(g)-(n). This includes medical malpractice claims for itself and its covered individuals. FHH is a nonprofit organization under section 501(c)3 of the IRS Code. This institution is an equal opportunity provider and employer.

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HSIM Unaccompanied Minor Consent

Due to the fact that patients seen on the Healthy Smiles Mobile Dental Units are unaccompanied by parents or guardians and that it is often difficult to contact them during the course of treatment, this consent will serve as authorization to perform necessary dental care on the minor patient.

I hereby authorize Family Healthcare of Hagerstown to perform the following procedures on the Healthy Smiles mobile dental units in my absence on

_____.

(Patient's Name and Date of Birth)

_____

(School Name)

We provide the full range of treatments/ services listed below, including, but not limited to:

PREVENTIVE: Dental Exams, Cleanings, X-rays, Fluoride Treatments, Sealants

RESTORATIVE: Fillings, Stainless Steel Crowns (silver crowns on badly decayed teeth, necessary when a filling will not work), Crowns on permanent teeth, Pulpectomies (cleaning/ removing infected nerve due to excessive decay), Local Anesthesia (numbing, which is necessary for nearly all restorative procedures), Nitrous Oxide (laughing gas)

EXTRACTIONS: Removal of either primary (baby) or permanent teeth

MISCELLANEOUS: Space Maintainers (to hold the place of prematurely lost baby teeth), Night Guards

If there are any of the above procedures you **DO NOT** want performed on the mobile units, please list them below. The child will need to be scheduled in the office:

_____

_____

_____ _____ _____

Parent/ Guardian Name Parent/ Guardian Signature Date

 Revised 07/06/2022