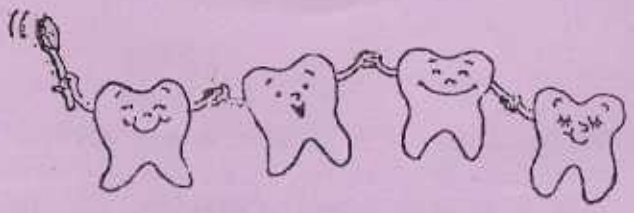

GOING MILES FOR HEALTHY SMILES

DENTAL HEALTH SERVICES

- DENTAL CLEANINGS
- FLUORIDE TREATMENTS
- DENTAL SEALANTS
- HOME CARE INSTRUCTIONS
- FREE TOOTHBRUSH & FLOSS
- FREE DENTAL SCREENINGS / REFERRALS

*Please return this form to the health office as soon as possible.

WAYNE COUNTY RURAL HEALTH NETWORK
WAYNE COUNTY PUBLIC HEALTH
RUSHVILLE HEALTH CENTER, INC./COMMUNITY DENTISTRY PROGRAM
2 RUBIN DRIVE/RUSHVILLE, NY/14544 (585)-554-4825

Child's Name: _____ Teacher/Grade: _____ / _____
(Teacher) (Grade)

Please check all that apply, and return to your child's teacher as soon as possible.

___Yes, I would like my child to receive a dental screening, dental cleaning, fluoride treatment, toothbrush and floss. Please complete the rest of page 2, 3 and page 4 to qualify for a discount.

___My child has Child Health Plus, Blue Cross/Blue Shield, or Medicaid insurance and I have completed the card information below

___My child does not have the dental insurance listed below (Child Health Plus, BC/BS Dental of the Rochester Area or Medicaid), and does not qualify for a discount. I have enclosed a check made out to the Rushville Health Center for $63.00 if child is 13years old & under; 14 and older $78.00 for dental cleaning , fluoride and screening.

___We qualify for a discount on page 4, and have enclosed a check and proof of income for the dental cleaning, fluoride and screening.

___I have other dental insurance, I have enclosed the insurance dental form completed and signed.

___Yes, I give permission for my child to have dental sealants if needed.

___Yes, I want my child to receive a free dental screening only and send home a report.

___No, I do not wish for my child to participate in the dental program.

Parent/Guardian Signature _____

After the dental visit, a report will be sent home and /or we will phone you regarding any concerns. If you have any questions please feel free to contact us at 585-554-4825.

BlueCross BlueShield of the Rochester Area
An Excellus Company
Dental Care Program

Subscriber Identification Number:
_____ - ___
Subscriber Name:
_____

BC PLAN BS PLAN

Customer Service 1-800-724-1675
TTY 585-454-2845
EXPRESSLINE 585-454-5010 1-800-548-6428

Insurance address if **not** Rochester:

_____

_____

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
BENEFIT
IDENTIFICATION CARD

ID NUMBER: _____
NAME: _____
SEX (M OR F) _____
BIRTHDATE: _____
ISO # ACCESS NUMBER SEQ #
____ _____ ____

Child Health Plan
BlueCross BlueShield

Subscriber Identification Number:
_____
Subscriber Name:
_____

BC Plan BS Plan

Customer Service 1-800-650-4359
When your doctor's office is closed call 1-800-718-4885
This coverage requires annual recertification

In order to treat your child we need the following information and your signature.

I consent to having my child receive dental care by the Rushville Health Center dental staff at school. My child may receive a dental screening, cleaning, and fluoride treatment. If my child has insurance, (Child Health Plus - Rochester Area, Medicaid, or Blue Cross/Blue Shield Dental - Rochester Area*) I consent for the Health Center's Billing Department to apply for dental insurance benefits from my child's insurance carrier. If your child has had a dental cleaning within the past 6 months, and you have used your insurance, you are not eligible for insurance reimbursement at this time. If your insurance covers partial payment or denies services you are financially responsible for the visit. I consent to having my child's doctor release my child's medical information to the dental staff if my child's health history shows health problems which may affect his/her dental treatment. The Rushville Health Center is in compliance with the Health Information Privacy Protection Act. I understand that I may contact the Rushville Health Center to have a copy of this act sent to me.

_____ _____ / _____
Print Name of parent/guardian Signature Date
(Parent/guardian must sign if patient is under 18 years of age)

Address _____ _____
Zip Code

Home Phone ( ) _____ - _____ Work Phone ( ) _____ - _____

Health Historv

Child's Name _____ M/F ____/____/____
First Last Birth date

Child's Social Security Number ____/____/____ School Name _____

Has your child ever had any of the following? Please check yes or no.

If you answer yes to any of the questions below please explain on the space provided.

	NO	YES		NO	YES
Heart trouble (including murmur, valve prosthesis)			Surgical implants or artificial joints		
Hepatitis A, B, C, or D			Seizures or epilepsy		
Blood disorder/anemia			Diabetes		
Surgery within past 5 year's			Tuberculosis / TB		
Kidney disease or trouble			Cancer		
Allergy to latex			Mental condition or disorder		
Allergy to medication			If yes to any questions please explain:		

Does your child have any disease, condition, or problem not listed above that you think we should know about?

Is your child being treated by a doctor for any reason? Yes No
If yes, please explain.

Who is your child's doctor? _____ (____)_____
Name Phone

Is your child taking any medication? (Be sure to include vitamins)

Has your child ever been in the hospital? Yes No
If yes, what for? _____

Is this your child's first dental visit? Yes No

Do you have any dental concerns? _____

Does your child drink fluoridated water? Yes No Does your child drink water from a well? Yes No

Who should we contact in case of an emergency? _____ (___)_____
Name Phone

Signature of parent/guardian _____ Date ____/____/____

Signature of Provider _____ Date ____/____/____

For office use only
R: _____
ID# _____

Your family may be eligible to receive dental services at a discount based on your family size and income. If you fall into one of the guidelines below please circle the household size and income. You will need to enclose a copy of your 2006 income tax return or pay stubs for 3 consecutive weeks showing gross income. (Copies may be made at your local library)

	20%		35%	
Household Size	Annual Income	Monthly Income	Annual Income	Monthly Income
1	$20,420.00	$1,701.67	$17,867.50	$1,488.96
2	$27,380.00	$2,281.67	$23,957.50	$1,996.46
3	$34,340.00	$2,861.67	$30,047.50	$2,503.96
4	$41,300.00	$3,441.67	$36,137.50	$3,011.46
5	$48,260.00	$4,021.67	$42,227.50	$3,518.96
6	$55,220.00	$4,601.67	$48,317.50	$4,026.46
7	$62,180.00	$5,181.67	$54,407.50	$4,533.96
8	$69,140.00	$5,761.67	$60,497.50	$5,041.46

For a dental cleaning, fluoride treatment, dental screening and toothbrush and floss:

35% discount for a child 13 years old and under is $ 40.95;
A child 14 years old and older is $50.70.

20% discount for a child 13 years old and under is $50.40;
A child 14 years old and older is$62.40.

Please make check or money order payable to Rushville Health Center, Inc.

Please be sure to complete and sign pages 2 and 3 if you want your child to participate in the dental program. Return this form as soon as possible. Thank you.

If your income is lower than these guidelines you may qualify for Child Health Plus. Their contact number is: 1-800-346-2211