DELTA DENTAL

MOBILE PROGRAM

Patient Information and Permission Form

General information

Patient information

Legal name (please print)

Age ______ Birth date (mm/dd/yyyy) ____/____/____

Sex ❑ Male ❑ Female

School attending ______ Grade ______

Race
- ❑ White ❑ Asian ❑ Other
- ❑ Black or African American
- ❑ American Indian or Alaska Native
- ❑ Hawaiian or Other Pacific Islander
- ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Parent/guardian information

Name (please print)

Relation to patient

Home (mailing) address

City ______ Zip ______

Home phone (______)______-______

Work phone (______)______-______

Cell phone (______)______-______

❑ Check here if you do not want to receive text messages.

Emergency contact information

Name (please print)

Relation to patient

Phone (______)______-______

Dental history

Dental visits should start at first tooth.

❑ Yes ❑ No Is this the patient's first dental visit?
If no, how long has it been?
❑ Less than 2 years ❑ More than 2 years

Past or current dentist's name

❑ Yes ❑ No Is the patient experiencing toothache/mouth pain/face swelling?

❑ Yes ❑ No Has the patient visited the ER/hospital for dental pain in the last year?

❑ Yes ❑ No Has dental pain caused you or your child to miss school and/or work in the last year?
❑ School ❑ Work ❑ Both

Medical history

Patient's current physician

Date of last medical exam (mm/yy) ____/____

❑ Yes ❑ No Is the patient taking any medications?

If yes, please list ______

❑ Yes ❑ No Does the patient have any allergies?

If yes, please list ______

❑ Yes ❑ No Does the patient have any special needs that would require special arrangements for dental care? e.g. autism

If yes, please explain ______

❑ Yes ❑ No Is the patient pregnant?

Does the patient have, or have they had, a history of the following:

❑ ADHD	❑ Cerebral Palsy	❑ Kidney disease
❑ AIDS / HIV	❑ Diabetes	❑ Liver disease
❑ Anemia	❑ Epilepsy/seizures	❑ Mono
❑ Anxiety	❑ Excessive bleeding	❑ Rheumatic fever
❑ Asthma	❑ Fainting	❑ Tuberculosis
❑ Birth defects	❑ Heart problems	❑ Other ______
❑ Cancer	❑ Hepatitis	

Please explain your answers:

Continue on back.

DELTA DENTAL®

MOBILE PROGRAM

Patient Information and Permission Form

Patient behavior

❑ Yes ❑ No Does the patient brush daily?

❑ Yes ❑ No Does the patient drink soda pop or other sugar-sweetened drinks (Kool-Aid, fruit drink, sports drink) daily?

❑ Yes ❑ No Is the patient using tobacco or vaping products?

❑ Yes ❑ No Does anyone in the household use tobacco or vaping products?

Household information

Annual household income

❑ Less than $10,000 ❑ $10,000-20,000

❑ $20,000-30,000 ❑ More than $30,000

How many children age 21 or younger live in your household?

____

Insurance

Please check any that apply.

❑ No dental insurance

❑ Medicaid

Medicaid number ____

❑ Private DENTAL insurance (please provide copy of card)

____

Dental insurance name

____

Policy number

____

Group number

____

Dental insurance address

Insurance phone (__________)__________-__________

____

Employer name

IMPORTANT - Permission to provide treatment

We cannot treat your child if form is not signed.

I, ____, as a legally responsible guardian of ____

Print parent/legal guardian name Print child's name

give my permission for the dental services I have authorized below. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular exams by a dentist. I have been offered and/or have read Delta Dental's HIPAA Notice of Privacy Practices available at southdakota.deltadental.com/privacy-and-policies/notice-of-privacy-practices/.

Each item needs to be answered in order to receive dental care.

❑ Yes ❑ No Preventive services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.

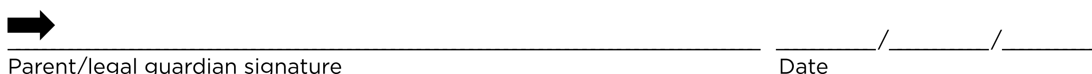
❑ Yes ❑ No Dentist exam (including dental x-rays)

❑ Yes ❑ No Restorative services: fillings, stainless steel crowns, pulpotomy. Local anesthetic may be used for these procedures.

❑ Yes ❑ No Silver diamine fluoride (decayed area of the tooth will be stained black permanently – please see attached for more information about this treatment)

❑ Yes ❑ No Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Local anesthetic may be used for these procedures.

❑ Yes ❑ No The use of nitrous oxide (laughing gas) may be used as deemed necessary.



____ ________/________/________

Parent/legal guardian signature Date

V1121

Fill out front too.

DELTA DENTAL

SILVER DIAMINE FLUORIDE INFORMED CONSENT

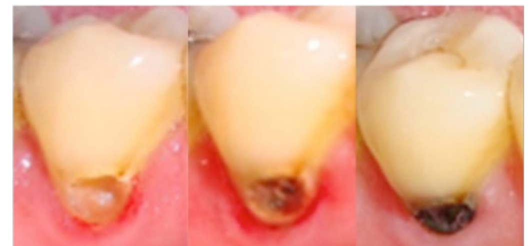
Silver Diamine Fluoride (SDF) is a liquid medication that is applied to active tooth decay to kill bacteria and stop the cavity from growing. We use SDF to prevent or stop tooth decay. We also use it to treat tooth sensitivity.

Benefits of receiving SDF:

- SDF can help stop tooth decay.
- SDF can postpone the need for traditional dental treatment (fillings, crowns, etc.) and delay/possibly eliminate the need for sedation/general anesthesia to complete dental treatment.

Risks related to SDF include, but are not limited to:

- Patients should not be treated with SDF if:
    - **He/she has an allergy to silver**.
    - There are painful sores or raw areas on the gums or anywhere in the mouth.
- **The decayed area of the tooth will be stained black permanently.** Healthy tooth structure will not stain.
- Tooth colored fillings and crowns may discolor if SDF is applied to them.
- If SDF contacts the gums or skin, a brown or white stain may appear. This color change is harmless, but cannot be washed off. The discoloration will go away in 1-3 weeks.
- If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such repeat SDF, a filling or crown, root canal treatment, or extraction.



before, after 24 hours, and after 7 days of SDF treatment (UCSF Dental Center)

Alternatives to SDF include, but are not limited to:

- No treatment. No treatment will allow untreated decay to continue further damaging tooth structure, possibly leading to pain, infection, or tooth loss.
- Fillings, crowns, extractions or referral for advanced care which may include general anesthesia.

While SDF can stop tooth decay, it will not restore the tooth structure that has already been effected. You may still require restoration of the teeth (fillings, crowns, etc.).

I certify that I have read and fully understand this document. All of my questions have been answered.

Patient Name: ____Date of Birth: ___________________

Parent/Legal Guardian Signature: ___________________________________Date: __________________

Parent/Legal Guardian Name (Please Print):____

This page is intentionally blank to accommodate double-sided printing.

DELTA DENTAL®

Nondiscrimination and Language Accessibility Statement

Discrimination is Against the Law

Delta Dental of South Dakota complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. Delta Dental of South Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes.
Delta Dental of South Dakota provides people with disabilities with reasonable modifications and free auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Delta Dental of South Dakota provides free language services to people whose primary language is not English, such as Qualified interpreters and Information written in other languages.
If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-877-841-1478.
If you believe Delta Dental of South Dakota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Delta Dental of South Dakota, Section 1557 Coordinator, 720 N. Euclid Ave., Pierre, SD 57501, phone: 1-877-841-1478, compliance@deltadentalsd.com, fax: 1-605-224-0909, TTY: 1-800-877-1113. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuitaɗ ayuda y servicios auxiliares apropiados para proporcionarka información en formatos accesibles. Llame al 1-877-841-1478 (TTY: 1-ɗ 800-877-1113) o hable con su proveedor.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-841-1478 (TTY: 1-800-877-1113) an oder sprechen Sie mit Ihrem Provider.

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-877-841-1478 (TTY: 1-800-877-1113) 或與您的提供者討論

ဆူ– နမ့ၢ်ကတိၤ ထါနၣ်လီၤဖဲအံၤ အဃိ, တၢ်အိၣ်ဒီး ကိၣ်တၢ်ဆီၣ်ထွဲမၤစၢၤ လၢတလၢ်ဘူၣ်လၢ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိၣ်ဒီး တၢ်မၤစၢၤတၢ်နၢ်ဟူပီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြၢးအဘၣ်လၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤန့ၢ်အီၤသ့တဖၣ် လၢတလၢ်ဘူၣ်လၢ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-877-841-1478 (TTY: 1-800-877-1113) မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ၣ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-841-1478 (Người khuyết tật: 1-800-877-1113) hoặc trao đổi với người cung cấp dịch vụ của bạn.

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-877-841-1478 (TTY: 1-800-877-1113) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

PAŽNJA: Ako govorite srpsko-hrvatski, besplatne usluge jezičke pomoći su vam dostupne. Odgovarajuća pomoćna sredstva i usluge za pružanje informacija u dostupnim formatima takođe su besplatno dostupne. Pozovite 1-877-841-1478 (TTY: 1-800-877-1113) ili razgovarajte sa svojim pružaocem usluga.

ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-877-841-1478 (TTY: 1-800-877-1113) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

KADNA: So k'ala Sudanic, shidma ɗiɓɓin ɗo fota seɓɓindi maa. Fomu ey goɗɓe ndiɗɗin ɗo waɗti hoɓɓin ɗo safango ɗey ɗogani ɗiɗɗin ɗey ɗɗon maa. Naɓɓo 1-877-841-1478 (TTY: 1-800-877-1113) o waɗɗa ka ngal ɗo.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-841-1478 (TTY: 1-800-877-1113) o makipag-usap sa iyong provide

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-841-1478 (TTY:1-800-877-1113)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-841-1478 (TTY: 1-800-877-1113) или обратитесь к своему поставщику услуг

ODUU: Yoo Afaan Oromoo dubbattu ta'e, tajaajilli gargaarsa afaanii tolaan siif jira. Tajaajila gargaarsaa fi meeshaaleen gargaarsaa odeeffannoo karaa salphaa siif dhiyeessuuf barbaachisu, kaffaltiin malee siif kennamu. Bilbili 1-877-841-1478 (TTY: 1-800-877-1113) yookiin gargaarsa kennituu kee waliin haasofi.

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-877-841-1478 (TTY: 1-800-877-1113) або зверніться до свого постачальника».

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-841-1478 (TTY: 1-800-877-1113) ou parlez à votre fournisseur.

Version: 11/04/2024