Grace Health
181 West Emmett Street
Battle Creek, MI 49037-2963
(269) 966-2625

grace HEALTH

Grace Health
115 Market Place
Albion, MI 49224-1767
(517) 629-6540

Mobile/Portable Dental Services

are coming to your school this school year 2024-2025

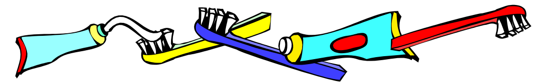
Dental services are provided by a
Grace Health Registered Dental Hygienist

Your child may receive:

- Dental Screening
- Oral Health
- Fluoride Varnish
- Sealants
- Cleaning
- Silver Diamine Fluoride

Dental Services are available to all that are uninsured or have Medicaid. These services will be completed at no cost to you.

***Dental After Hours Emergency:**
Call 269-965-8866 to speak to a nurse*



Please complete the attached consent forms, then return them to your child's teacher or Email them to:
PortableConsent@gracehealthmi.org

Prior to Grace Health going to your child's school for Dental Services, a reminder will be sent home.

Contact the Portable Dentistry Coordinator with questions or concerns at 269-441-6805.

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Portable Dental Services Consent

School ____________________
Grade ____________________
Teacher ____________________

This consent is for dental services for your child at his/her school.

Please complete the information, sign, and date bottom of this form.

Child's Last Name	First Name	Middle Initial	Date of Birth	Sex
Street Address	Apt. #	City	State	Zip Code

Parent/Guardian	DOB	Home Telephone Number ( )	Daytime Number ( )	Cell Number ( )
Parent/Guardian	DOB	Home Telephone Number ( )	Daytime Number ( )	Cell Number ( )

Race	❑ White ❑ Asian	❑ Black / African American ❑ American Indian / Alaska Native	❑ Native Hawaiian ❑ Other Pacific Islander	❑ Choose not to disclose ❑ Other____________
Ethnicity	❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unreported/Choose not to disclose	Language	❑ English ❑ Spanish ❑ Burmese ❑ Other____________	

Reporting yearly household size and income is a government requirement that will allow Grace Health to continue to receive funding to provide special services for our patients. Please support these programs by providing the following information:

Number of people living in home: ________ *Total household income:* ____________ *Choose not to disclose:* _____

Medical Information

Medical doctor's name:

My child takes medicine .... If yes, please list:

My child has:

- Allergies .... If yes, please list:
- Asthma .... If yes, is inhaler needed at time of dental visit?................................
- Heart problems such as artificial heart valve, previous endocarditis, damaged (scarred) heart valves, congenital heart defects, heart transplant ....

Dental Information

Does your child have dental insurance?

Dental insurance company:

My child's dentist:

Has your child had a cleaning within the last 6 months?

I understand by signing this form, I am consenting to:

- having my child receive dental services which <u>may</u> include screening (for dental disease), oral health instruction, fluoride varnish application, sealants, and a cleaning.
- allow Grace Health staff to release my child's dental records to his/her school.
- allow Grace Health staff to take photos of my child's dental screenings for educational/marketing purposes.
- services completed may affect my child's insurance benefits with his/her primary dentist. Please contact us with any questions.

By signing, I also acknowledge that I have received a copy of this office's Notice of Privacy Practices.

______________________________________ (Signature of Parent or Legal Guardian)

______________________ (Date)

Please Return to Classroom Teacher or Email to PortableConsent@gracehealthmi.org

For Office Use Only

Child's Last Name	First Name	Middle Initial	Date of Birth	Sex

Date	School

Teacher	Grade	Chart #

(please circle or check appropriate box)

Screening – Oral Hygiene Assessment

- ❑ **Excellent:** no plaque or food debris / no inflammation
- ❑ **Good:** slight plaque and food debris / slight gingival inflammation
- ❑ **Fair:** moderate plaque and food debris / moderate inflammation observed
- ❑ **Poor:** heavy plaque and food debris / significant inflammation observed

Caries Risk Assessment

- ❑ Low
- ❑ Moderate
- ❑ High

Patient experiencing dental symptoms and/or exhibits apparent pathology

- ❑ No
- ❑ Yes – Comments ______________________________

____

____

Patient sees dentist regularly

- ❑ Yes
- ❑ No

Prophylaxis

- ❑ Yes
- ❑ No

Fluoride Varnish Application

- ❑ Yes
- ❑ No

Sealants – tooth number(s)

❑ 2	❑ 14	❑ 18	❑ 30
❑ 3	❑ 15	❑ 19	❑ 31

Sealants – retention check

2 ❑ Yes ❑ No	14 ❑ Yes ❑ No	18 ❑ Yes ❑ No	30 ❑ Yes ❑ No
3 ❑ Yes ❑ No	15 ❑ Yes ❑ No	19 ❑ Yes ❑ No	31 ❑ Yes ❑ No

Comments: ______________________________

____

Hygienist Signature: ______________________________

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Patient Name:____________________________

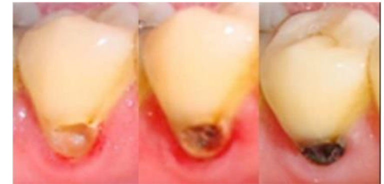
Date of Birth:_____________________________

INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE

Facts for consideration:

- Silver Diamine Fluoride (SDF) is a liquid that helps stop tooth decay. SDF may be applied every 3, 6 or 12 months.
- A small amount of SDF may be applied to the decayed tooth area.
- After SDF application no eating or drinking for 30 minutes.

Pictures of stain from SDF.



Benefits of receiving SDF:

- Helps stop decay.
- Fast.
- Do not need to numb, or drill teeth.
- Does not hurt.

Risks of receiving SDF:

- The affected area will stain black permanently. This means the SDF is working.
- Tooth-colored fillings and crowns may discolor if SDF is applied to them. Healthy tooth structures will not stain.
- If accidentally applied to skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off and will disappear in one to four weeks.
- Could permanently stain clothing dark.
- Might not stop the decay. Additional SDF may need to be applied on a different day.
- After SDF treatment, a filling or crown might still be needed.
- Not all decay can be treated with SDF.

Risk if not treated:

- If decay is NOT treated, it may get worse, and you may lose the tooth or may need more dental work to save the tooth. If not treated, you may experience tooth pain or a life-threatening condition.

I should not be treated with SDF if:
1) I am allergic to silver
2) there are painful sores or raw areas on my gums or anywhere else in my mouth.

I HAVE READ AND UNDERSTAND THIS FORM. ALL OF MY QUESTIONS ABOUT TREATMENT, INCLUDING THE BENEFITS, SIDE EFFECTS, AND RISKS WERE ANSWERED.

I consent and authorize __________________________________ to use Silver Diamine Fluoride to help stop tooth decay.

Patient name: ____

Parent/Guardian name: ____

Signature:____ Date: _______________

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Effective: April 14, 2003
Revised: July 1, 2019

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Notice of Privacy Practices

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We create a record of all the medical, pharmacy and dental services that you receive at Grace Health. This record contains information about your symptoms, examinations, test results, x-rays, diagnoses, treatment, our plan for future care and the services we have provided.

At Grace Health, we respect our patients and their personal information. We are committed to protecting the privacy of patient records. We are also required by state and federal laws to maintain the privacy of protected health information.

One of the requirements of the federal Privacy Rules is to provide patients with a Notice of Privacy Practices. This notice tells how we may use your patient information and how it may be disclosed to others. It also explains your rights and some of our legal obligations regarding your health records.

Uses and disclosures of health information

Grace Health employees may use or disclose your patient information to provide treatment, obtain payment and carry out health care operations.

Treatment: Your patient information is used by the people taking care of you at our office. We may also share information with others who are helping us provide treatment for you, such as a medical specialist, hospital, laboratory or pharmacy.

Payment: Your patient information may be used as we bill and collect payment for the treatment and services you receive. We may contact your insurance company to verify coverage, and we may share the information with them to obtain payment for services we have provided or to request authorization for treatment. Information may be disclosed to our collection agency in case of non-payment for services.

Operations: We may use your health information as we operate and manage our practice and to make sure that you and our other patients receive quality care. This includes using patient information to evaluate the performance of our staff, to find ways to become more efficient and to decide what services to offer. When information is shared with others who provide business services for our organization, they are also required to protect the privacy of our patient information.

Appointment reminders and leaving messages: We may contact you or leave a message on an answering machine or with a household member to remind you of your appointment. We may also leave messages about the status of services we are providing for you or to request return calls to our office.

Text messaging: If you share your cell phone number with us, appointment reminders and payment alerts may be sent in text messages. We may also send you information about tests, appointments and other procedures for which you are due. Text messaging is optional, so you may opt out at any time.

Other electronic communication: We may securely send or receive messages through the Patient Portal. We do not use email to communicate with individual patients or receive messages from them.

Treatment alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Fundraising: Some patients may receive letters requesting donations to Grace Health. If you do not want to be on that mailing list, you may contact us by phone or mail.

Emergency situations: In the case of a medical emergency, your information may be disclosed without obtaining a signed authorization to prevent delays in treatment. We may not be able to honor any normal restrictions on use or disclosure if emergency treatment is required. We may notify your family members, caregivers, and/or close friends in case of a medical emergency or if you are incapacitated. We may also share information that relates to their involvement in your health care based on our professional judgment if we determine it is in your best interest.

Disclosures permitted by law: We may disclose information about you without your permission if permitted or required by law. This includes the following situations:

- Immunization records – Immunization records will be reported to the Michigan Care Improvement Registry (MCIR).
- Public health authorities – We will disclose information to your county health department if you have one of the communicable diseases that must be reported under Michigan law. Information may be reported to state or federal agencies regarding preventing or controlling disease, workplace injuries and adverse events related to food or medical products.

(over)

- Controlled substance reports – If our pharmacy dispenses a controlled substance, we will report all details of the prescription and your government-issued ID to the State of Michigan.
- Court order – We will release any information requested in a court order or a subpoena issued by an official of the courts.
- Minor's confidential information – If you are a minor seeking your own care as allowed by law, we may contact your parents with information about your condition if it is determined medically necessary by a health care provider. Your parents may also become aware of the treatment if they are responsible for payment for the services.
- Abuse or neglect – We will report cases of suspected abuse or neglect to Child Protective Services or Adult Protective Services as required by law.
- Domestic abuse – We will report cases of domestic abuse to the authorities as required by law.
- Law enforcement – We may release information to law enforcement as needed to avert a serious health or safety threat or to locate a suspect, fugitive, material witness or missing person. We may release information to law enforcement for investigation of illegal activities involving controlled substances.
- Dental records – Dental records may be released to law enforcement to identify a deceased or missing person.
- Deceased patients – Information about deceased patients may be disclosed to the medical examiner, funeral director or an institutional review board such as the Fetal Infant Mortality Review.

Integrated Health Partners (IHP): We are a member of this hospital physician organization whose activities include medical insurance support, quality improvement and a community collaborative for chronic disease and case management. Your information may be shared with the IHP staff and partnering providers for those purposes.

Health Information Exchange: Other healthcare organizations providing care for you and clinical record extract services providing information to your insurance company may be able to view your health records electronically. Contact our Privacy Officer if you wish to opt out from this electronic exchange.

Video Recording: With your signed consent, your medical appointment with a resident may be recorded for educational purposes.

Other uses and disclosures: We will obtain written authorization from you or your legal representative for any uses or disclosures that are not described above, are not permitted by law or are not related to treatment, payment or health care operations. You may revoke a previously made authorization by providing written notice.

Notification of breaches: We will make every effort to protect the privacy of your health information. We will notify you by mail about a breach of confidentiality.

Patient rights

You have the following rights regarding your health records:

- Right to request restrictions on uses or disclosures – You have the right to request that we place limitations on our use or disclosure of your patient information. We have the right to choose not to agree to the requested restriction.
- Right to receive confidential communications – You have the right to request that we use alternative methods to contact you. We have the right to choose not to agree to the request.
- Right to inspect and copy – You have the right to make an appointment to review your health records. You may also request to receive a copy of your records at a reasonable fee. You may request that the records be provided in electronic format.
- Right to amend – You have the right to add a written statement to your records to clarify or correct the information within your medical or dental chart.
- Right to receive an accounting of disclosures – You have the right to request a list of all disclosures made without your written authorization that were not made for the purposes of treatment, payment or health care operations.
- Right to restrict disclosures to health plan – If you pay in full for services, you can request that information about those visits is not provided to your health insurance plan.

Changes to this notice

We reserve the right to revise this notice when there has been a material change in our privacy practices. We will abide by the terms of the notice currently in effect. The current version of the notice will be posted at Grace Health and on our website at www.gracehealthmi.org. You may contact us to receive a written copy.

Questions or complaints

If you have questions about this notice or Grace Health's privacy practices, please contact our Privacy Officer at (269) 965-8866. If you believe your privacy rights have been violated, you may contact our Privacy Officer. You may also file a written complaint with the Department of Health and Human Services. You will not be retaliated against for filing a complaint.