

# DENTAL AND MEDICAL MOBILE SERVICES



The Northeast Missouri Health Council (NMHC) is excited to partner with your school to provide dental and medical services at school during normal school hours. A variety of services will be provided.

The Mobile Dental Program will accept MO HealthNet, Home State, UHC Community Plan, and Healthy Blue. There is no cost or financial requirement to the parent if the student is covered by one of these plans. If the child is uninsured, NMHC staff will work with the parent/guardian to verify eligibility and/or apply for appropriate coverage, if applicable.

The Mobile Medical Program will file all medical insurances. If the child is uninsured, NMHC staff will work with the parent/guardian to verify eligibility and/or apply for appropriate coverage, if applicable.

**The attached packet must be filled out and returned to the school nurse or school office before the child can be scheduled for either of the mobile programs. The consent form in this packet must be signed by a parent or guardian.**

MOBILE PROGRAMS are scheduled to be at your school during the school year. Appointments are limited, please return all completed forms to the school nurse ASAP as priority is given to students who return the completed paperwork promptly, as well as those who have the greatest needs. If you have questions, please contact your school nurse or the school office. We look forward to working with you and your child!

Northeast Dental  
402 W. Jefferson St.  
Kirksville, MO. 63501  
660.665.2741

Northeast Family Health  
1416 Crown Drive  
Kirksville, MO. 63501  
660.627.4493

***Please return completed packets to your  
school ASAP!***



**Consent to Treat/Mobile Medical & Dental Unit/Parent Not Present**

\_\_\_\_\_  
 Child's Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 DOB

\_\_\_\_\_  
 Child's School

This document is my consent as parent/guardian of the above-named child for any treatment or procedure deemed necessary by the professional staff of Northeast Missouri Health Council while my child is on the MOBILE MEDICAL & DENTAL UNIT.

**MEDICAL** – These treatments and procedures include, but are not limited to, wellness exams, vaccinations, sick visits.

**DENTAL** - These treatments and procedures include, but are not limited to, dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays, crowns, pulp treatments, and extractions.

Please list any specific limitations for this authorization: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 PRINTED Parent/Guardian Name

\_\_\_\_\_  
 Relationship to Patient

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 DATE

Date ____/____/____	School:	
Grade:	Teacher:	
<b>CHILD'S INFORMATION</b>		
FNAME:	M.I.	LNAME:
DOB: ____/____/____	Age:	Gender:
Mother's Maiden Name:	Preferred Language:	
Child's Primary Doctor:	Child's Primary Dentist:	
Does child have prescription drug coverage?    Yes    or    No	Preferred Pharmacy:	
Is the child homeless or displaced?    Yes    or    No	Child's race and ethnicity:	
<b>PARENT/GUARDIAN CONTACT INFORMATION</b>		
Parent/Guardian Name:	Parent/Guardian DOB: ____/____/____	
Address:	Parent/Guardian SS#: ____-____-____	
City/State/Zip:		
Primary Phone #: (    ) ____-____ <i>is this a cell # Y or N</i>	Alternate Phone #: (    ) ____-____	
<b>EMERGENCY CONTACT INFORMATION</b>		
Name of Emergency Contact (other than parent):	Relationship to Child:	
Phone # of Emergency Contact: (    ) ____-____		
<b>INSURANCE INFORMATION</b>		
<b>Is Child Covered by Missouri MEDICAID/Mo HealthNet (including Healthy Blue, United Healthcare Community Plan, or Home State Health Plan?)</b>		
<b>YES    or    NO</b>		
If YES, what is the MEDICAID #/DCN?		
Is child covered by OTHER MEDICAL or DENTAL INSURANCE?    YES    or    NO <i>(If yes, fill out as much information as known about other dental ins below)</i>		
If YES, what is the type/name?		
Policy #:	Group #:	
Address to mail claims:		
Policy Holder Name:		
Policy Holder DOB: ____/____/____	Policy Holder SS#: ____-____-____	
Policy Holder Relationship to Child:		



**This health history information will be used by, and my child is signed up to see:**

- BOTH** Mobile Medical and Mobile Dental     
  **ONLY** Mobile Medical     
  **ONLY** Mobile Dental

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_

**Who is filling out this form?**

- Mother     
  Father     
  Other guardian (please explain relationship to child) \_\_\_\_\_

**The child's parents are:**

- Single     
  Married     
  Divorced     
  Separated but not divorced     
  Widowed

**MEDICAL HISTORY – Please Complete if your child is seeing Medical AND/OR Dental**

1. Please check any of the following **medical problems** that your child **has** or has **ever** been diagnosed with.

<b>ADD/ADHD</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Anxiety or Depression</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Artificial Joint Placement</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Asthma</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Back problems</b> (scoliosis, back pain)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Blood clotting disorder or Abnormal Bleeding</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Congenital Heart Defects or Heart Murmur</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diabetes</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diarrhea or Constipation</b> (having frequent and runny bowel movements, having difficulties having a bowel movement.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Ear infections</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Eating Disorders</b> (Anorexia, Bulimia)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Mitral Valve Prolapse</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Mouth or throat problems</b> (Strep throat, swallowing problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Muscle and bone problems</b> (weak muscles, pain in joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Nose problems</b> (sinus infections, nose bleeds)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Neurological Disorders</b> (Autism, head injury, seizures, headaches)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Problems urinating</b> (bed wetting, pain when urinating)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Skin problems</b> (acne, flaking skin, rashes, hives)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sleeping problems</b> (falling or staying asleep)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Vision or Hearing problems</b> (blurry vision, need to wear glasses, difficulty hearing, deaf)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Please list any other medical problems or diagnoses that are not listed above:</b>	

2. Has your child ever had any **surgeries**?

- No  
 Yes (If yes, please list type of surgery and when.)

Surgery Performed:	When

(Please use the back of this form if you need to list additional surgeries.)  Additional list on back

3. Is your child taking any **prescription medicines**?

- No. My child does not take any prescription medicines.  
 Yes - Please list the child's medicines below

Name of medicine	Amount / size of pill	How many pills or doses does your child take at
<b>Example:</b> Dexadrine	10 mg	<u>  1  </u> morning <u>  </u> noon <u>  </u> evening <u>  1  </u> bedtime
		<u>  </u> morning <u>  </u> noon <u>  </u> evening <u>  </u> bedtime
		<u>  </u> morning <u>  </u> noon <u>  </u> evening <u>  </u> bedtime

(Please use the back of this form if you need to list additional medications.)  Additional list on back

4. What **over-the-counter medicines**, does your child take regularly?

- Vitamins  
 Herbal medicine (please list) \_\_\_\_\_  
 Other (please list) \_\_\_\_\_  
 None, my child does not take any over-the-counter medicines regularly.

5. Does your child have any **allergic reaction** from any of the following? (Check all that apply.)

- Outside or Indoor allergies (for example: grass, pollen, cats)  
 Food Allergies (for example: peanuts, milk, wheat)  
 **LATEX** (for example: dental gloves)  
 Medicine or shots (immunizations or dental local anesthetics). (Please list below.)  
 No, my child has no allergies that I know of.

Medicine child is allergic to:	What happens when the child takes that medicine

**FAMILY**

6. Check all the people that the **child lives with**:

- Mother       Father       Brothers (how many? \_\_\_\_\_)       Sisters (how many? \_\_\_\_\_)  
 Other family members or friends (list \_\_\_\_\_)

6. Please mark medical history that the child's **immediate family** has been diagnosed with.

<b>Family Member</b>	<b>Medical Problems</b>
Mother:	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety (nerve) problems <input type="checkbox"/> Learning disability <input type="checkbox"/> Overweight <input type="checkbox"/> High blood pressure <input type="checkbox"/> Diabetes (sugar) <input type="checkbox"/> Cancer <input type="checkbox"/> Heart problems Other: _____
Father:	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety (nerve) problems <input type="checkbox"/> Learning disability <input type="checkbox"/> Overweight <input type="checkbox"/> High blood pressure <input type="checkbox"/> Diabetes (sugar) <input type="checkbox"/> Cancer <input type="checkbox"/> Heart problems Other: _____
Sisters:	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety (nerve) problems <input type="checkbox"/> Learning disability <input type="checkbox"/> Overweight <input type="checkbox"/> High blood pressure <input type="checkbox"/> Diabetes (sugar) <input type="checkbox"/> Cancer <input type="checkbox"/> Heart problems Other: _____
Brothers:	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety (nerve) problems <input type="checkbox"/> Learning disability <input type="checkbox"/> Overweight <input type="checkbox"/> High blood pressure <input type="checkbox"/> Diabetes (sugar) <input type="checkbox"/> Cancer <input type="checkbox"/> Heart problems Other: _____

**Dental History: COMPLETE ONLY IF YOUR CHILD IS BEING SEEN ON MOBILE DENTAL UNIT**

8. Date of last dental exam: \_\_\_\_\_ Office/Dentist Name: \_\_\_\_\_

<b>Has your child ever:</b>	
Been seen by a dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been sedated for dental surgery or had dental treatment in a hospital setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had nitrous, ('laughing gas') for dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Orthodontic work	<input type="checkbox"/> Yes <input type="checkbox"/> No
Teeth extractions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have pain with any of their teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No



**Consent for Immunization on Mobile Medical Unit**

- I consent for my child to receive any of the below vaccinations for which they are due.
- I **DO NOT** consent for my child to receive vaccinations on the mobile medical unit.

**IF THERE ARE ANY VACCINATIONS LISTED BELOW WHICH YOU DO NOT WANT YOUR CHILD TO RECEIVE, PLEASE DRAW A LINE THROUGH THE NAME AND PLACE INITIALS BESIDE THE LINE.**

Tetanus, Diphtheria, Acellular Pertussis (Tdap)

Human Papilloma Virus (HPV)

Meningococcal (Menactra)

Meningococcal-B (Bexsero)

9. Please list any other pertinent information about your child that you would like for us to know.

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Printed Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

# HIPAA & INS/TX AUTH

## Mobile Medical/Dental Unit



PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
*(Please Print)*

### NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used for: **treatment, payment, and healthcare operations**. NMHC’S NOTICE of PRIVACY PRACTICES is posted in each clinic reception area, is available from any front desk associate, and can be viewed online at [nemohealthcouncil.com](http://nemohealthcouncil.com). I understand Northeast Missouri Health Council, Inc. (NMHC, Inc.) has the right to change its Notice of Privacy Practices from time to time. My signature below indicates I have read and understand NMHC’s Notice of Privacy Practices.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### ASSIGNMENT OF INSURANCE BENEFITS & TX AUTH:

I, the undersigned, authorize my insurance benefits to be paid directly to the provider of the Northeast Missouri Health Council, Inc. (NMHC, Inc.), for services rendered. I understand that I am ultimately financially responsible for any balance due not paid by insurance. I hereby authorize NMHC, Inc., to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

I, the undersigned, consent to Northeast Missouri Health Council providers and staff to perform medical/dental examinations, testing and treatment as directed by my provider. I understand that I have the right to discuss with my provider the purpose, potential risks, and benefits of any ordered tests or treatment options. I understand that if invasive or interventional tests or procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures. I understand that the consent will remain fully effective until it is revoked in writing.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



**NORTHEAST MISSOURI HEALTH COUNCIL**

**FY2024**

As a Federally Qualified Health Center (FQHC), we are required to report economic data on our patients. Please find your household size and appropriate income category on the chart below and report the category such as 1A or 4D, etc. NMHC, Inc., appreciates your cooperation and wants to assure you that we only report de-identified (no names or medical information) data.

Household Size	A	B	C	D	E	F
1	0 - 14,580	14,581 - 18,225	18,226 - 21,870	21,871 - 25,515	25,516 - 29,160	29,161 & above
2	0 - 19,720	19,721 - 24,650	24,651 - 29,580	29,581 - 34,510	34,511 - 39,440	39,441 & above
3	0 - 24,860	24,861 - 31,075	31,076 - 37,290	37,291 - 43,505	43,506 - 49,720	49,721 & above
4	0 - 30,000	30,001 - 37,500	37,501 - 45,000	45,001 - 52,500	52,501 - 60,000	60,001 & above
5	0 - 35,140	35,141 - 43,925	43,926 - 52,710	52,711 - 61,495	61,496 - 70,280	70,281 & above
6	0 - 40,280	40,281 - 50,350	50,351 - 60,420	60,421 - 70,490	70,491 - 80,560	80,561 & above
7	0 - 45,420	45,421 - 56,775	56,776 - 68,130	68,131 - 79,485	79,486 - 90,840	90,841 & above
8	0 - 50,560	50,561 - 63,200	63,201 - 75,840	75,841 - 88,480	88,481 - 101,120	101,121 & above
	<i>add \$5,140 per</i>	<i>add \$6,425 per</i>	<i>add \$7,710 per</i>	<i>add \$8,995 per</i>	<i>add \$10,280 per</i>	

*\*For families with more than 8 members add the appropriate figure noted in each column per additional member.*