CORNERSTONE CARE
COMMUNITY HEALTH CENTERS

Cornerstone Care Mobile Dental Program

DELTA DENTAL

- Signature required. Signed consent includes initial visit and 6-month checkups when appropriate.
- Treatment is limited to exams, cleanings, fluoride, x-rays, sealants, and referral when necessary.
- Please send a photocopy of your insurance card for verification of coverage and eligibility.

Health and General Information– PLEASE PRINT CLEARLY IN INK & COMPLETE ALL SECTIONS FRONT & BACK

Child's Legal Name:_____Child's Date of Birth:_____

Home Address:_____
Street City Zip Code

Child's Social Security Number: _____-_____-_____ Child's Gender: M F (Circle one)

Race: ☐ White ☐ African American ☐ Asian ☐ Bi-Racial ☐ Native Hawaiian ☐ Pacific Islander ☐ American Indian

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

School: _____ Teacher: _____ Grade: _____

Parent/Guardian Name:_____ Phone Number:_____

Parent/Guardian email address:_____ Parent/Guardian's Date of Birth:_____

***IMPORTANT**: List all medical conditions, medications, & allergies. Attach another page if more space is needed.

☐ Medical Conditions:_____
☐ Medications:_____
☐ Allergies:_____
☐ Dental Issues:_____

***Emergency Contact**

Contact Name:_____
Phone Number: _____
Relationship: _____
Primary Care Physician:_____
PrimaryDental Provider:_____

***Insurance Information**

I have medical insurance for my child: **Yes or No

What is the name of your child's primary medical insurance company? _____
ID Number:_____
Date of child's last dental visit:_____
I would like my child to be a member of the kids club:
Yes No (Circle one)
Name of Dental Insurance Company:
_____
ID Number:_____
Group Number:_____
Name that appears on dental insurance card:
_____

I would like information on obtaining insurance for my child: **Yes or No

HOUSEHOLD INCOME INFORMATION			
Enter the number of dependents you claim on your income taxes below	✓ The Appropriate Income Box	Yearly Income Between	
		0	12760
		12761	17240
		17241	21720
		21721	26200
		26201	30680
		30681	35160
		35161	39640
		39641	44120

Insured Parent's Date of Birth:_____Address:_____

Social Security number of the parent on the dental insurance card:_____-_____-_____
Telephone number shown on dental insurance card:_____

Insured parent/guardian employer name:_____ Relationship to child:_____

Please check: _____Yes, I give permission for my child to participate in the Cornerstone Care dental program during the current school term. I understand that my child will receive a dental exam, dental cleaning, fluoride, x-rays, and sealants if recommended by the dentist.

X:_____ _____

Signature of Parent/Guardian **Date**

Please Fill Out Back Side

_____
Name of Patient – please print

United Way
United Way of Washington County Community Partner

CORNERSTONE CARE
Acknowledgement of Receipt of Notice of Privacy Practices

Cornerstone Care has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement. We reserve the right to change out Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to Contact our Privacy Officer:
Mail: Cornerstone Care, Attention: Privacy Officer, 7 Glassworks Road, Greensboro, PA 15338
Telephone: (724) 943-3308 Fax: (724) 943-3310

Acknowledgement of Receipt:

I acknowledge that I have received that Notice of Privacy Practices for Cornerstone Care.

X_____ _____
Signature of Parent/Guardian **Date**

Consent to Disclosure of Personal Health Information to your child's School District
AND
Consent to Disclosure of Personal Health Information to Cornerstone Care

I,_____, give my permission to the staff of Cornerstone Care to release
(Parent/Guardian name)
information regarding my child's medical and dental care, including my medical or dental condition, test results, appointment dates/times to the child's School/School District **AND** I give my permission to the staff of the School/School District to release information regarding my child's medical and dental care, including my medical or dental condition, test results, appointment dates/times to Cornerstone Care.

X_____ _____
Signature of Parent/Guardian **Date**

Good Faith Efforts to Obtain Acknowledgement of Receipt

I provided the above-named patient/parent/guardian with the Notice of Privacy Practices.
Describe how notice was provided:
X Copy of Privacy Notice enclosed in Cornerstone Care Mobile Dental Program Parent Consent Sheet

Describe efforts to obtain signature on acknowledgement of notice form:
☐ Parent/Guardian was asked to sign form and refused, returned form unsigned

_____ _____
Cornerstone Care Mobile Unit Outreach Specialist Date

Questions or Concerns
Contact: Cornerstone Care Outreach Department
Telephone: (724)-852-1001