Dear Parent/Guardian:

Greenwood Leflore Hospital’s Children’s Clinic and your child’s school are on a mission to improve the health and well-being of our children. The Children’s Clinic pediatricians have partnered with a local dentist and optometrist to provide EPSDT screenings at surrounding schools.

Greenwood Children’s Clinic School Kids program works in collaboration with the State of Mississippi, Division of Medicaid’s EPSDT program, a healthcare program for Mississippi’s children ages birth up to 17. The School Kids program services include: comprehensive health and developmental history, comprehensive physical exams, appropriate immunizations, laboratory tests including lead toxicity screenings, adolescent counseling, health education, vision, hearing, and dental services.

What does EPSDT stand for?

- **Early** - Early identification of problems your child may be having
- **Periodic** - Checking children’s health as recommended for their age
- **Screening** - Conducting physical, mental, developmental, dental, hearing, vision, and other screening tests to find potential problems
  - After your child’s initial vision screening, if a more detailed exam is needed we will refer your child to our partner Dr. Todd Hall or an eye doctor of your choice.
  - Depending on your child’s age, blood tests will be performed to detect anemia, lead exposure, triglycerides, and RPR.
- **Diagnosis** - Performing diagnostic tests or refer your child for testing when a risk is identified
- **Treatment** - If problems are found that need to be addressed, we can treat them at the clinic with a follow up visit.

Why are we dedicated to providing your child this service? We believe routine exams, including dental and vision screenings help millions of children stay healthy, which promotes success in school.

In order for your child or children to receive these exams, the attached forms must be completed and returned to the school as soon as possible.

We look forward to serving your child. If you have questions, please contact our School Kids Coordinator: 662.459.7030.

Sincerely,

The Children’s Clinic
School-Based Wellness Visit Parent Agreement and Consent for Treatment

Child’s Name: ________________________________________________________________________________________
Birthdate: ________/________/________ Printed name of Parent/Guardian: __________________________________________
Emergency contact number(s):  (  ) ___________-______________ (  ) ___________-______________

A. CONSENT FOR TREATMENT: I consent to allow GLH Children’s Clinic and its affiliates to furnish medical treatment deemed necessary and appropriate for EPSDT School based screenings outlined in this document.

B. CONSENT FOR USES DISCLOSURES OF HEALTH INFORMATION: I consent to GLH and its affiliates to use and disclose my child’s health information for Treatment, Payment and Health Operations. I understand that I may obtain the Notice of Privacy Practices and Patient Grievance Policy which outlines my rights with respect to the uses and disclosure of health information. I may obtain a paper copy from the Children’s Clinic’s School Kids Program Coordinator or an electronic copy at http://www.glh.org/inc/privacyPractices2013.pdf.

C. ASSIGNMENT OF BENEFITS REIMBURSEMENT RIGHTS: I hereby irrevocably assign and transfer payment directly to GLH any benefits payable to me, not to exceed GLH’s regular charges, including but not limited to automobile insurance (medical payments, liability, uninsured and underinsured, worker’s compensation, homeowner’s, premises, produce liability, malpractice, health, hospitalization, Medicare, Medicaid, and applicable benefit, verdict or settlement), and agree GLH has the right to make direct demands to a third party for such payment. I authorize the hospital to obtain any information they deem necessary, including insurance information and accident reports.

D. PROMISE TO PAY: I acknowledge I am responsible for any and all charges incurred, and agree to pay any balance not covered by insurance or hospital benefits programs, including all attorney and/or collection fees and costs necessary to obtain payment of the bill. I also acknowledge GLH has a lien on any claim that may have contributed to medical services rendered, and authorize any insurer or my attorney to apply to GLH directly. I also acknowledge that GLH will be billing for services rendered.

E. MEDICARE/MEDICAID STATEMENT AND CERTIFICATION: If applicable, I certify I am an eligible recipient under the Medicaid Program, Title XIX of the Social Security Act. If applicable, I also certify I am an eligible recipient under the Medicare Program, Title XVIII of the Social Security Act. I understand that if I falsely represent and/or provide false documentation to claim eligibility for Medicare, Medicaid or other government health program benefits, I risk being charged by the government for fraud and if convicted, will be subject to fines and imprisonment.

F. RETIREMENT OF DATA MATTER: I authorize GLH to retire, destroy, or otherwise dispose of x-rays or other data after the customary time span, and to dispose of any medical waste and human tissue in a manner GLH deems appropriate.

G. BY MY SIGNATURE below I certify, as the parent or legal guardian of the student named above, I understand that the EPSDT services will include the following: comprehensive health and developmental history, comprehensive physical exams, appropriate immunizations, laboratory tests including lead toxicity screenings, adolescent counseling, health education, vision, hearing, and dental services.

I acknowledge that all information provided on the Greenwood Leflore Hospital’s forms entitled: School-Based Wellness Visit Parent Agreement and Consent for Treatment, Patient Health Questionnaire and Demographic Form is accurate and complete. I HAVE READ THIS FORM CAREFULLY AND I UNDERSTAND THAT IF I HAVE ANY QUESTIONS I MAY CALL THE GREENWOOD CHILDREN’S CLINIC SCHOOL KIDS PROGRAM COORDINATOR AT 662.459.7030 FOR ANY EXPLANATION(S) BEFORE I SIGN THIS AUTHORIZATION.

_________________________________________________________________/_____/__________________________
Signature of Parent/Guardian Date

School: __________________________
Grade: __________
Parental Consent

Student Name: ______________________________________________________________________________________

Birthdate: ________________________________________  SSN: ________________________ Sex: □ Male  □ Female

PARENTAL CONSENT FOR DENTAL EXAMINATION

Todd Fincher, DDS
113 East Market Street
Greenwood, MS 38930
662.453.1708

Child’s Dental Information:
Does your child have any dental pain? □ No  □ Yes  If yes, how long? ________________________________________

Please indicate any of the following problems:
___ Discomfort, clicking or popping jaw  ___ Lost/broken filling (s)  ___ Stained teeth  ___ Locking jaw
___ Red, swollen or bleeding gums  ___ Teeth grinding  ___ Ringing in ears  ___ Bad breath
___ Blisters/sores in or around mouth  ___ Broken/chipped tooth  ___ Loose tooth
___ Other (s): _______________________________________________________________________________________

Does your child require pre-medication? □ No  □ Yes  If yes, how long? ________________________________________

Previous dentist: _______________________________________________  or  □ My child has never seen a dentist

Last dental exam date: _____/_____/_____  Last dental x-rays date: _____/_____/_____

Times per day child brushes: ____________  Times per day child flosses: _______________

Is child allergic to:
___ Latex  ___ Penicillin  ___ Tetracycline  ___ Dental anesthetics (Novacaine)
___ Aspirin  ___ Food allergies; If yes, please list: __________________________________________________________________
___ Other: _________________________________________________________________________________________

Does child do any of the following:
___ Thumb/finger suck  ___ Tongue thrusting/sucking
___ Mouth breathing  ___ Lip sucking/biting

☐ I authorize Todd Fincher, DDS, and his licensed staff to provide my child with dental exams, x-rays, and fluoride. Those services will be billed to your insurance; however you will not be billed for any out of pocket expenses. If the minor is already under the care of a family dentist, please continue your routine to arrange dental care for your minor through your dentist.

☐ I do not want my child to have his/her teeth and mouth examined.

Please note: Dental services will be filed with your insurance; however, if you do not have insurance or your insurance does not pay you will NOT be billed for any dental services.

____________________________________ / ____/__________________________
Signature of Parent/Guardian  Date
Demographic Form

STUDENT/PATIENT INFORMATION

Name of School:  _____________________________________________________________________________________

Student Name:  ______________________________________________________________________________________

Mailing Address:  ____________________________________________________________________________________

Birthdate: ________________________________________  SSN: ________________________  Sex:  □ Male  □ Female

Home Phone: _____________________________________  Parent Cell Phone: _____________________________________

Parent’s email address:  ________________________________________________________________________________

Medicare/Medicaid/MSCAN/CHIPS: _________________________________  Policy #: ________________________________

Name on Card: _______________________________________________________________________________________

Date of Birth: ______________________________________  SSN: ______________________________________________

Address:  ___________________________________________________________________________________________

PRIVATE OR SECONDARY Insurance: _______________________________  Policy #: _________________________________

Guarantor/Subscriber Name: ___________________________________________________________________________

Guarantor/Subscriber DOB: ____________________________ Guarantor/Subscriber SSN: _____________________________

Guarantor/Subscriber Address: __________________________________________________________________________

Pharmacy (Drug Store) Name: __________________________ City: ______________________________________________

Primary Care/Referring Provider: __________________________________________________________________________

Signature of Parent/Guardian  / / __________________________

Date

Please complete this entire form. It will be used to update your records for this visit and to allow us to contact you if there are any questions or concerns regarding your care and treatment.

Thank you,
GLH and Participating Providers
New Patient Health Questionnaire

Child's Name: _________________________________________ Date of Birth   ____/_____/_____   Male     Female

List any allergies: _____________________________________________________________________________________
__________________________________________________________________________________________________

List current medications: ________________________________________________________________________________
__________________________________________________________________________________________________

Mother's age at birth? _________________________________

Did she take any medication other than vitamins and iron?  
Yes   /   No

How many weeks gestation at delivery? ____________________

Please indicate if mother had any of the following during pregnancy:
□ HIV  □ Hepatitis  □ Group B Strep (GBS)  □ Chlamydia
□ Gonorrhea  □ Herpes  □ Genital Warts

Baby's Birth History

Was baby born on time?  Yes   /   No

Baby's birth Weight: _______________ Length: ____________

Did the baby have any trouble starting to breath?  Yes   /   No

Did the baby have any problem while in the hospital 
(such as jaundice, infections, other?) Yes   /   No

If yes, what kind____________________________________

Feeding & Nutrition

Is your child’s appetite usually good?  Yes   /   No

If no, is it good now?  Yes   /   No

Any colic or feeding problems?  Yes   /   No

Any foods that disagree with him/her?  Yes   /   No

Breast fed or bottle?  __________________________________

If on formula, which one?  __________________________________

Does he/she take vitamins?  Yes   /   No

Please see reverse side for more information.
New Patient Health Questionnaire

Please indicate answers by filling in the blanks, or by checking the appropriate box(es)

CHILD’S HEALTH HISTORY

Development and Behavior
At what age did your child sit alone? _______________________
At what age did he/she walk alone? _______________________
Did he/she say any words by the time he/she was 1-½ yr. old?
   Yes   /   No
Any other problems? ______________________________________

Safety and Environment
Do you live in a private house, apartment, home? ______________
Do you know the temperature of your water? _________________
Does your smoke alarm work?  Yes   /   No
Are there smokers in the home?  Yes   /   No
Are there any problems with peeling paint, insects, rats or mice?
   Yes   /   No

Past Medical Visit & Allergy History
Where has your child gone for check-ups until now? ___________
Date of last check up? _______________________________
Date of last vision test? _______________________________
Has your child had any allergic reaction to any medications, food,
   or insect bites? Yes   /   No
If yes, which one? ______________________________________
Recent visit to the ER?  Yes / No   If yes, Date of ER visit________
Reason for ER visit ______________________________________

Previous Hospitalizations
Any hospitalization/surgeries or ER visits? Yes   /   No
If so, please list reason: __________________________________
Date: __________________________________________

Previous Medical History
☐ Eczema                        ☐ Diarrhea
☐ Ear Infection                ☐ Pneumonia
☐ Chicken Pox                  ☐ Asthma
☐ Anemia                       ☐ Recurrent Cough
☐ Heart Murmur or Problems    ☐ Urination Problems
☐ Convulsions/Seizures/Nerve Problems
☐ Developmental/Speech Delays
☐ Sore Throats
☐ Dental Problems: ______________

☐ Vision Problems: ______________________________
☐ Other: ______________________________________

Past Surgical History
☐ Appendectomy                  ☐ Adenoidectomy
☐ Dental Surgery                ☐ Inguinal hernia repair
☐ Tonsillectomy                ☐ Umbilical hernia repair
☐ Tubes placement
☐ Other: _________________________

Previous Immunizations
Are your child’s immunizations up to date: Yes   /   No
Has she/he had a bad reaction to any immunizations? Yes   /   No
Which ones : ______________________________________

Signature of Parent/Guardian ____________________________
Date _______________________________________________