

Southeast Health District **TELEDENTISTRY**



Your child can receive dental services without missing school!

Dental Services Provided

- ♦ Oral Health Screening
- ♦ Dental X-Rays
- ♦ Teeth Cleaning
- ♦ Oral Home Care Education
- ♦ Oral Hygiene Kit
- ♦ Fluoride and Sealant Application
- ♦ Record Review with Treatment Plan
- ♦ Referral for Follow-up Services

Healthy Teeth Tips

1. Brush twice a day for two minutes with a soft bristle toothbrush.
2. Floss at least once a day.
3. Visit a dentist every six months for a regular checkup, starting at the age of one year.
4. Eat a well-balanced diet, and limit sugary and acidic foods/drinks.
5. Replace your toothbrush every three months.
6. Ask your dentist if a nightly fluoride rinse would be beneficial to your oral health routine to help prevent cavities.



For more information:
Southeast Health District Office of Teledentistry
1101 Church Street
Waycross, GA 31501
912-287-4893



Southeast Health District

OFFICE OF TELEDENTISTRY
1101 Church Street, Waycross, Georgia 31501
Phone: 912-287-4893 Fax: 912-287-6657

Rosemarie D. Parks, M.D., M.P.H.
District Health Director

August 2020

Dear Parent/Guardian,

The **Southeast Health District (SEHD) Teledentistry Program** is ready for the 2020-2021 school year. **Teledentistry is NOT a mobile van or bus clinic.** Please read carefully as we want your child to be a part of the program.

The Teledentistry program offers affordable preventive visits during the school day. We provide an oral health screening, dental x-rays, prophylaxis (cleaning), fluoride varnish, sealants (if recommended), oral home care instructions, treatment plan with referral (as needed), and an oral hygiene kit to take home.

Our supervising dentist, along with Augusta University Dental School, provide oversight to the SEHD Teledentistry Program by utilizing videoconferencing technology. Your child's dental insurance provider will be billed for services. If your child isn't currently covered by insurance, a sliding fee scale will apply.

The teledentistry clinic is located in your child's school. If your child does not attend the school where the clinic is located, he/she will be transported by school bus to the clinic. The SEHD team works closely with the school transportation department and school nurse in your county for scheduling.

Your child's dental record will be maintained by SEHD Teledentistry Program and can be forwarded to a dental office at any time it is requested. If your child is treated in the teledentistry clinic, his/her records are reviewed by the advising dentist to create a treatment plan. You will receive a referral letter from the SEHD Teledentistry Program, via the school, within a week of the child's visit to the clinic. For your benefit, included in this letter you will receive a resource list of dental providers that currently accept Medicaid insurance. Please use this guide to find a dental provider for your child, if applicable. You will also receive a follow up phone call a few weeks from the date of service.

If your child does **NOT** have a local dentist, the SEHD Teledentistry Program contracts with a local dentist whom we may refer your child to for dental treatment.

The SEHD Teledentistry Program wants your child to have a healthy mouth and a successful school year. By seeking the recommended dental treatment, you can increase the likelihood of both. Our team looks forward to seeing your child in the teledentistry clinic, where we will provide dental education and preventive treatment. If you have questions or concerns about our program please call Kayla Daniels, RDH at 912-287-4893. You may also contact your child's school nurse.

Appling
Atkinson
Bacon
Brantley

Bulloch
Candler
Charlton
Clinch

Coffee
Evans
Jeff Davis
Pierce

Tattnall
Toombs
Ware
Wayne

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SOUTHEAST HEALTH DISTRICT - TELEDENTISTRY: MEDICAL/DENTAL HISTORY

PLEASE FILL IN ALL SPACES (PLEASE PRINT) - SIGN/DATE BELOW

CHILD'S LEGAL NAME: (FIRST) _____ (MIDDLE) _____ (LAST) _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____ **COUNTY:** _____

BIRTHDATE: (MONTH) _____ (DAY) _____ (YEAR) _____ **AGE:** _____ **GENDER:** ☐ MALE ☐ FEMALE

PARENT/GUARDIAN'S NAME: _____ **RELATIONSHIP TO PATIENT:** _____

TELEPHONE NUMBERS: (HOME) _____ (CELL) _____ (WORK) _____

SCHOOL ATTENDING: _____ **HOMEROOM TEACHER:** _____ **GRADE:** _____

***CHILD'S MEDICAL DOCTOR:** (NAME/CITY/PHONE) _____

***CHILD'S CURRENT DENTIST & DATE OF LAST VISIT:** _____

ETHNIC BACKGROUND: ☐ ASIAN ☐ BLACK ☐ HISPANIC ☐ WHITE ☐ OTHER

PLEASE ANSWER THE FOLLOWING QUESTIONS *PROVIDE DETAILS FOR ANY "YES" ANSWERS

☐ CITY (PUBLIC) WATER ☐ WELL WATER ***WHAT IS THE PRIMARY SOURCE OF YOUR CHILD'S DRINKING WATER (NO BOTTLED)?**

YES NO DOES YOUR CHILD TAKE ANY MEDICATIONS ON A REGULAR BASIS? (*LIST ALL MEDS)

YES NO IS YOUR CHILD ALLERGIC TO ANY MEDICATION/FOOD/OTHER? (*IF YES, EXPLAIN) _____

YES NO HAS YOUR CHILD EVER BEEN HOSPITALIZED? (*IF YES, EXPLAIN) _____

YES NO HAS YOUR CHILD EVER HAD PROBLEMS WITH PREVIOUS DENTAL TREATMENT? (*IF YES, EXPLAIN) _____

YES NO HAS YOUR CHILD RECENTLY BEEN SUFFERING FROM DENTAL PAIN/SWELLING/PROBLEMS? (*IF YES, EXPLAIN)

YES NO DOES YOUR CHILD HAVE A DENTAL CONDITION/PROBLEM WHICH YOU ARE ESPECIALLY CONCERNED?

(*IF YES, EXPLAIN) _____

YES NO IS THIS YOUR CHILD'S FIRST DENTAL EXPERIENCE?

****DENTAL INSURANCE INFORMATION:** (PLEASE INDICATE WHAT INSURANCE COMPANY THE PATIENT IS COVERED BY)

☐ GA MEDICAID

☐ WELLCARE/AVESIS

☐ FL MEDICAID

☐ NO INSURANCE COVERAGE

☐ AMERIGROUP/DENTAQUEST

☐ OTHER/PRIVATE/UNKNOWN INSURANCE:
(*Please list)

☐ CARESOURCE/SCION

☐ PEACHSTATE/ENVOLVE

****MEMBER ID # ON CARD:** _____

TOTAL NUMBER OF PERSONS LIVING IN HOUSEHOLD: _____ **TOTAL HOUSEHOLD MONTHLY GROSS INCOME:** \$ _____

***PARENT/GUARDIAN (SIGNATURE):** _____ **DATE:** _____

- AIDS/HIV POSITIVE
 - ANEMIA
 - ARTIFICIAL JOINTS/VALVES
 - ASTHMA
 - ATTENTION DEFICIT DISORDER (ADD, ADHD) ***IS MED TAKEN DAILY?** _____
 - AUTISM
 - BLEEDING EASILY/EXCESSIVELY
 - BLOOD DISEASE/DISORDER
 - BLOOD TRANSFUSION
 - BONE DISORDER
 - BRAIN DISORDER
 - CANCER
 - CEREBRAL PALSY
 - CHEMOTHERAPY TREATMENT
 - COLD SORES/FEVER BLISTERS
 - DIABETES ***TYPE?** _____
 - DOWN SYNDROME
 - EAR/NOSE/THROAT CONDITION
 - EPILEPSY *** WITH SEIZURES?** _____
 - FAINTING/DIZZINESS
 - FOOD ALLERGIES
 - EYE DISORDER/GLAUCOMA
 - HEADACHES (FREQUENT)
 - HEART CONDITION (CIRCLE ALL THAT APPLY:)
(IRREGULAR HEARTBEAT/ARTIFICIAL HEART VALVE/HEART MURMUR/HEART SURGERY/
OTHER: _____)
 - HEMOPHILIA/BLEEDING TENDENCY
 - HEPATITIS A/B/C (CIRCLE ALL THAT APPLY)
 - HIGH BLOOD PRESSURE
 - JAUNDICE
 - KIDNEY DISEASE
 - LEUKEMIA
 - LIVER DISEASE
 - LOW BLOOD PRESSURE
 - MENTAL DISABILITY
 - MUSCLE DISORDER
 - OPPOSITIONAL DEFIANT DISORDER (ODD)
 - PREGNANT
 - PREMEDICATION NEEDED
- *EXPLAIN:** _____

- PSYCHIATRIC CARE
- RASH/HIVES
- RADIATION TREATMENT
- RESPIRATORY/BREATHING PROBLEM
- RHEUMATIC FEVER
- SCARLET FEVER
- SCOLIOSIS
- SEIZURES (NOT ASSOC. WITH EPILEPSY)
***EXPLAIN:** _____
- SICKLE CELL ANEMIA
- SKIN DISEASE
- SPEECH PROBLEM
- SPINA BIFIDA
- STD(s)
- STOMACH DISORDER/INTESTINAL PROBLEMS/ULCERS
- THYROID DISEASE
- TUBERCULOSIS
- TUMORS/GROWTHS

☐ **NO KNOWN HEALTH CONDITIONS**
(*CHECK HERE IF YOUR CHILD DOES NOT HAVE ANY HEALTH PROBLEMS)

➤ **PLEASE EXPLAIN EACH CONDITION YOU HAVE CHECKED ABOVE AND LIST ANY MEDICATIONS. IT IS VITAL THAT WE HAVE A COMPLETE & ACCURATE MEDICAL HISTORY, AS IT HAS A DIRECT IMPACT ON THE PATIENT'S ORAL HEALTH.**

***PARENT/GUARDIAN (SIGNATURE):** _____ **DATE:** _____



Southeast Health District

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1101 Church Street, Waycross, Georgia 31501
Phone: 912-287-4893 Fax: 912-287-6657

Rosemarie D. Parks, M.D., M.P.H.
District Health Director

CONSENT FOR TELEDENTISTRY SERVICES

PLEASE READ, COMPLETE BOTTOM PORTION, AND RETURN TO SCHOOL

- * I hereby authorize the Southeast Health District and affiliated associates to perform preventive dental services on my child including: dental screening, exam, radiographs, photographs, intraoral pictures, prophylaxis (cleaning), fluoride varnish, restorative treatment, sealants & patient education.
- * I authorize the Southeast Health District to verify insurance coverage & eligibility by acquiring employment, financial, medical history & other related matters deemed necessary for billing purposes.
- * I authorize the Southeast Health District to bill the patient's insurance provider for the services provided in the SEHD teledentistry clinic.
- * I approve the release & disclosure of my child's medical/dental records to other healthcare/dental providers as requested by the healthcare/dental provider or the parent/guardian.
- * I have received and understand the Ware County Board of Health notice of privacy practices (attached as last page of this packet)
- * I have read & agree to the terms above & have provided true and accurate information concerning the patient and myself to the best of my knowledge.

CHILD/PATIENT NAME: (PRINT) _____

PARENT/GUARDIAN NAME: (PRINT) _____

PARENT/GUARDIAN SIGNATURE: _____

TODAY'S DATE: ____/____/____

Appling
Atkinson
Bacon
Brantley

Bullock
Candler
Charlton
Clinch

Coffee
Evans
Jeff Davis
Pierce

Tattnall
Toombs
Ware
Wayne

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PARENT QUESTIONNAIRE – TELEDENTISTRY 2020-2021

PLEASE COMPLETE ALL OF THE QUESTIONS BELOW TO THE BEST OF YOUR KNOWLEDGE. THIS INFORMATION ALLOWS US TO COLLECT DATA CONCERNING ORAL HEALTH KNOWLEDGE AND TO TRACK CURRENT BARRIERS FAMILIES FACE WHEN SEEKING DENTAL TREATMENT IN RURAL AREAS. THANK YOU FOR YOUR PARTICIPATION.

1. How would you rate the health of your child's teeth/mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. How often has your child complained of dental pain/problems/swelling in the past year?

☐ Never ☐ Sometimes ☐ Often

3. Approximately how long ago did your child visit a dentist? (not including the school program)

☐ 6 months ago or less ☐ 6 mo-1 year ago ☐ 1-2 yrs ago ☐ more than 2 yrs ago ☐ Never

4. Why did your child last visit a dentist?

☐ Cleaning/checkup ☐ Dental pain/problem ☐ Treatment of a previously diagnosed problem
☐ Never ☐ Other, explain: _____

5. If your child needed dental treatment and did NOT receive it, what is the primary reason? (please choose the best answer)

☐ Financial issue ☐ Transportation issue ☐ Too busy/forgot ☐ Cannot take off work/school
☐ Cannot find a dental provider that accepts my insurance ☐ Didn't think it was a priority
☐ Other, explain: _____

6. How often does your child brush their teeth?

☐ 1x morning only ☐ 1x night only ☐ 2x (once morning and once night) ☐ More than 2x day

7. How often do you supervise/assist your child when brushing their teeth?

☐ Never ☐ Sometimes ☐ Often

8. How many times a day does your child consume sugary/acidic snacks or drinks between meals? (ex. Candy, chips, juice, sweet tea, sports/energy drinks)

☐ Never ☐ 1x day ☐ 2x day ☐ 3x or more day

9. How often does your child use a fluoride rinse, tablet, or drop at home?

☐ Never ☐ Sometimes ☐ Often

10. Has your child ever had a dental screening/cleaning in their school Teledentistry clinic? (you would have received a referral letter (via school) and follow-up phone call from our program)

☐ Yes ☐ No

11. If yes to question #10, please rate your family's experience with the Teledentistry program.

☐ Excellent ☐ Good ☐ Fair ☐ Poor

12. What county do you live in?

☐ Brantley ☐ Charlton ☐ Clinch ☐ Other

13. Do you have any recommendations or suggestions for improvement concerning our program?

NOTICE OF PRIVACY PRACTICES FOR WARE CO BOARD OF HEALTH

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Ware County Board of Health to maintain the privacy of your health information inform you of its legal duties and privacy practices with respect to your health information through this Notice of Privacy Practices notify you if there is a breach involving your protected health information agree to restrict disclosure of your health information to your health plan if you pay out-of-pocket in full for health care services, and abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this Notice at any time. The Notice will be posted on the DPH website at www.dph.georgia.gov. Copies of the Notice are available upon request.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment: We may use or disclose your health information to provide you with treatment or services. We may disclose your health information to doctors, nurses or other healthcare personnel involved in your care. For example, we may share your information with programs involved in your follow-up care, such as the Babies Can't Wait program. Also, the DPH Public Health Laboratory will return lab test results to the person who ordered the tests, and those results may be used for your treatment or follow-up care.

Payment: We may use or disclose your health information to bill and collect payment for the services that you receive. For example, your health insurance company may need to provide your health plan with information about the treatment you received so that it can make payment or reimbursement for services provided to you.

Health Care Operations: We may use and disclose information about you for health care operations. For example, we may review treatment and services to evaluate the performance of our staff in caring for you, and to determine what additional services should be provided.

Appointment Reminders, Follow-Up calls: We may use or disclose medical information about you to remind you of an upcoming appointment or to check on you after you have received treatment.

Individuals Involved in Your Care: If you do not object, we may disclose your health information to a family member, relative, or close friend who is involved in your care or assists in taking care of you. We may also disclose information to someone who helps pay for your care. We may disclose your health information to an organization assisting with disaster relief to help notify your family member, relative, or close friend of your condition, status and location.

Business Associates: We may disclose your information to contractors (business associates) who provide certain services to us. We will require these business associates to appropriately safeguard your information.

Public Health Activities: We may disclose your health information for public health activities which include: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting reactions to medications or problems with products or notifying a person of product recalls; and notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your medical information to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only disclose this if you agree, or when required or authorized by law or regulation.

Health Oversight Activities: We may disclose your health information to a health oversight agency that is authorized to conduct audits, investigations, inspections, licensure and other activities necessary to monitor the health care system, government programs and compliance with civil rights laws.

Judicial and Administrative Proceedings: We may disclose your health information if ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process, but only if reasonable efforts have been made to notify you of the request or to protect the health information requested.

Law Enforcement: We may release health information to law enforcement to comply with a court order, warrant, subpoena or similar process to identify or locate a suspect, fugitive, material witness or missing person about the victim of a crime in certain circumstances if we believe a death resulted from criminal conduct to report a crime occurring on our premises in emergencies, to report a crime, the location or victims of the crime, or the identity, description and location of the person committing the crime.

Research: Under certain circumstances we may use or disclose your health information for research. In most cases, we will ask for your written authorization before doing so. Sometimes, we may use or disclose your health information for research without your written authorization. In those cases, the use or disclose of your health information without your consent will be approved by an Institutional Review Board or Privacy Board.

Coroners, Medical Examiner and Funeral Directors: We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

To Avert a Serious Threat to Health or Safety: We may use or disclose your health information if necessary to prevent or lessen a serious and imminent threat to your safety, another person, or the general public. We will only disclose your information to a person who can prevent or lessen that threat.

National Security and Intelligence Activities and Protective Services for the President: We may disclose your health information to authorized federal officials conducting intelligence and other national security activities. We may also disclose your health information to authorized federal officials for the provisions of protective services to the President, other authorized persons, foreign heads of state or to conduct special investigations.

Military and Veterans: We may disclose the health information of Armed Forces personnel to appropriate military command authorities for the execution of their military mission. We may also disclose health information about foreign military personnel to foreign military authorities.

Inmates: If you are an inmate, we may disclose your health information to the law enforcement official or correctional institution having custody to provide you with health care, and to protect your health or safety or that of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation: We may release your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

As Required by Law: We will disclose your health information when required to do so by law.

Except in limited circumstances, we must obtain your authorization for 1) any use or disclosure of psychotherapy notes 2) any use or disclosure of your health information for marketing, and 3) the sale of your health information. If your health information has information relating to mental health, substance abuse treatment, or HIV/ AIDS, we are required by law to obtain your written consent before disclosing such information. Any other use or disclosure not mentioned in this Notice will be made only with your written authorization, and you can revoke that authorization at any time. The revocation must be in writing, but will not apply to disclosures made in reliance on your prior authorization.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy your records. You must submit your request in writing to the Privacy Officer, Ware County Board of Health, 604 Riverside Ave, Waycross, Ga 31501 and include your name, date of birth, social security number, and the location where services were received if you received services at a local county health department. We may deny your request and in some circumstances, you may request a review of the denial.

Right to Electronic Copy of Electronic Medical Records: If your health information is maintained in electronic format, you have the right to request an electronic copy of those records. The information will be provided in the format requested if possible, within 30 days. We may charge a reasonable cost-based fee for transmitting the electronic record.

Right to Request an Amendment of PHI: You may request that we amend information that we have about you, for as long as we keep that information. You must submit your request in writing to the Privacy Officer, Ware County Board of Health, 604 Riverside Ave, Waycross, Ga 31501 and include your name, date of birth, social security number, a reason that supports your request, and the location where services were received if you received services at a local county health department. Your request may be denied if 1) the information was not created by us unless the creator of the information is not available to make the requested amendment, 2) the information is not kept by us 3) the information is not available for your inspection, or 4) the information is accurate and complete.

Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date on which the accounting is requested. The accounting will not include any disclosures 1) to you or your personal representative 2) made pursuant to your written authorization 3) made for treatment, payment or business operations 4) made to your friends and family involved in your care or payment for your care 5) that were incidental to permissible uses or disclosures of your health information 6) of limited portions of your health information that excludes identifiers 7) made to federal officials for national security and intelligence activities, and 8) to correctional institutions or law enforcement officers about inmates. To request an accounting of disclosures, submit your request in writing to the Privacy Officer, Ware County Board of Health, 604 Riverside Ave, Waycross, Ga 31501. Please include your name, date of birth, social security number, the period for which the accounting is being requested, and the location where services were received if you received services at a local county health department.

Right to Request Restrictions: You may request that we restrict the way we use and disclose your health information for treatment, payment or health care operations. You may also request that we limit how we disclose your health information to a family member, relative or close friend involved in your care or payment for your care. We are not required to agree to your request, but if we do, we will comply with your request unless you need emergency treatment and the information is needed to provide the emergency treatment. We may terminate our agreement to a restriction once we notify you of the termination. To request a restriction on the use or disclosure of your health information, please send your request in writing to the Privacy Officer, Ware County Board of Health, 604 Riverside Ave, Waycross, Ga 31501. Please include your name, social security number, and date of birth, what information you want to limit, to whom you want the limitation to apply, and the location where services were received if you received services at a local county health department.

Right to Request Confidential Communications: You may make reasonable requests to receive communications of your health information by alternate means or at alternate locations. For example, you may ask to be contacted only by mail, and not by phone. To request confidential communications, please send your request in writing to the Privacy Officer, Ware County Board of Health, 604 Riverside Ave, Waycross, Ga 31501. Please include your name, social security number, date of birth, how you would like to be contacted, and the local county health department where you received services.

Right to Receive a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice, which you may request at any time. You may obtain a paper copy by writing to the Privacy Officer, Ware County Board of Health, 604 Riverside Ave, Waycross, Ga 31501.

COMPLAINTS

If you believe that your privacy rights have been violated, you may send a written complaint to the Privacy Officer, Ware County Board of Health, 604 Riverside Ave, Waycross, Ga 31501. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

For further information you may contact the DPH Privacy Officer, Ware County Board of Health at 912-283-1875.

THIS NOTICE IS EFFECTIVE 17 September 2013.