Community Health Center of the North Country
School Based Health Center- Dental Enrollment Form
2017-2018

Student's Name: _____
(First) (Middle Initial) (Last)

Students School: _____ Grade: _____ Teacher: _____

The dental screening & sealants are free of charge to all children. We are required to bill Private Dental Insurance, Fidelis, Medicaid, and Managed Medicaid if sealants are applied. No fees will be billed if the child does not have dental insurance or if the dental insurance does not cover the complete costs.

Parents/guardians are welcome to attend your child's appointment. To coordinate a time & date please contact the school's health office in advance of our visit. A report of our findings & recommendations of treatment will be sent home with each child. Our findings can also be forwarded to your child's dentist if specified.

If you have any questions, contact your school nurse /teacher or the Community Health Center of the North Country at 386-8191, Ext. 8170. For any emergencies occurring after-hours please call 386-8191. You will be connected to our call center or contact 911.

*****Please remember this preventive service does not take the place of your child's regular dental care*****

Check one: ☐ **Yes,** I want my child to participate in the preventative dental sealant program at my child's school. *** If yes, please sign below and continue filling out ALL pages of form. ALL COMPLETED FORMS MUST BE RETURNED TO SCHOOL ASAP!**

☐ **No,** I do not want my child to participate in this program.

*** If No, please sign here** _____ **and return form to school**

☐ My child is a patient of Community Health Center of the North Country (CP Clinic)

☐ My child regularly goes to another dentist.

☐ **Yes,** please forward findings/ treatment provided to my child's regular dentist.

Name & Address of Dentist: _____

☐ **No,** I do not want treatment forwarded to my child's regular dentist.

☐ My child does **not** have a regular dentist.

Would you like a copy of our HIPPA policy sent home with your child? ☐ YES ☐ NO

I consent for my child to participate in the Community Health Center of the North Country Dental Sealant Program. I consent to further screening if deemed necessary at a later date to ensure dental health. I consent for the Community Health Center of the North Country to release my child's protected health information for the purposes of providing treatment to my child, obtaining payment for care, and conducting health care operations. I understand that this information will be shared only with authorized personnel and will be kept strictly confidential. I acknowledge that I have been offered a copy of the "privacy practices" for Community Health Center of the North Country.

Printed Name of Authorized Representative _____

Signature of Authorized Representative _____

Relationship to Child _____ **Date** _____

Student Information

Student's Name: _____
(First) (Middle Initial) (Last)

Date of Birth: _____ Student's Sex: ☐ M ☐ F Student's SSN: _____

Race/ethnicity (check all that apply): ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic
☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Pacific Islander ☐ More than 1 race
☐ Do Not Wish to Report

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Other: _____

Parent/Guardian Contact Information

Parent/Guardian Name: _____ DOB: _____
Relationship to Student: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Okay to leave message: ☐ YES ☐ NO
Employer: _____ Work Phone: _____

Parent/Guardian Name: _____ DOB: _____
Relationship to Student: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Okay to leave message: ☐ YES ☐ NO
Employer: _____ Work Phone: _____

Emergency Contact Person (if parents are not available): _____

Relationship to student: _____ Phone: _____

Dental Insurance

In order for this program to sustain we are required to bill the child's dental insurance
You will **NOT** be charged if treatment is not covered or is only partially covered

If insurance payment is mailed directly to you, please sign the check and mail it to:
CHCNC 4 Commerce Lane, Canton, NY 13617 Attn: Dental

Insurance Co. Name: _____
Insurance Co. Address: _____
Policy Holder's Name: _____ **Policy Holder's DOB**: _____
Policy Holder's Address: _____
Policy Holder's SSN: _____ Student's relationship to Policy Holder: _____
Policy ID #: _____ **Group #:** _____
Employers Name: _____
☐ No Dental Coverage

Medical & Dental History

Student's Name: _____
(First) (Middle Initial) (Last)

Medical History: has your **child** had any history of, or conditions related to, any of the following

☐ Asthma ☐ ADHD/Mental Health ☐ Diabetes ☐ Seizures
☐ Fainting ☐ Hepatitis ☐ Heart Murmur ☐ HIV-AIDS
☐ Cerebral Palsy ☐ Other _____

Does your child have any allergies (food, drug, environmental)? ☐ Yes ☐ No

If yes, describe: _____

Does your child have an allergy to pine or pine nuts? ☐ Yes ☐ No

List any medications that the child is taking: _____

_____

Do you have any concerns with your child's teeth, mouth, or gums? ☐ Yes ☐ No

If yes, describe: _____

Has your child had any problems with dental treatment in the past? ☐ Yes ☐ No

If yes, describe: _____

Would you like your child to receive a fluoride treatment? ☐ Yes ☐ No

FOR STAFF ONLY:

Medical History Reviewed by: _____ Date of Service: _____
School: _____ Grade: _____

2-O	2-L	3-O	3-L	14-O	14-L	15-O	15-L
31-O	31-B	30-O	30-B	19-O	19-B	18-O	18-B

Referral: REG IMM IRR

Fluoride: YES NO REFUSED

N/T SEALED UE Filled

Other: _____

Signature of Dental Employee: _____