

# Community Health Center of the North Country School Based Health Center- Dental Enrollment Form 2018-2019

Student's Name: \_\_\_\_\_  
(First) (Middle Initial) (Last)

Students School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

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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\*\*\***

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**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 HIPAA policy sent home with your child?  YES  NO

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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

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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

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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

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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: \_\_\_\_\_

Medicaid, Fidelis, or Dentaquest #: \_\_\_\_\_

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

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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

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## 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: \_\_\_\_\_