



2021-2022

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

Student's 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. You will NOT be billed if your 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 and 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. If you would like, our findings can also be forwarded to your child's dentist.

If you have any questions or need help filling out this form, please contact Community Health Center of the North Country at (315) 379-8207. For any dental emergencies occurring after-hours, please call (315) 379-8100 to 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 Dental Sealant Program at my child's school
*If yes, please sign at the bottom of this page and continue filling out ALL pages of this 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 at Community Health Center of the North Country
- My child regularly goes to another dentist
- Yes, please forward findings/treatment provided to my child's regular dentist

Name & Address of Dentist: _____

Date of child's last preventative dental appointment: _____

- 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

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 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 Pacific Islander
 American Indian/Alaska Native Native Hawaiian Multiple Races 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: _____ Zipcode: _____

Home Phone: _____ Cell Phone: _____ OK to Leave Message? Yes No

Employer: _____ Work Phone: _____

Parent/Guardian Name: _____ DOB: _____

Relationship to Student: _____

Mailing Address: _____

City: _____ State: _____ Zipcode: _____

Home Phone: _____ Cell Phone: _____ OK 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, you are responsible for signing and mailing the check to: CHCNC 4 Commerce Lane Canton, NY 13617 Attn: Dental Billing

Insurance Company Name: _____

Medicaid, Fidelis or Dentaquest # _____

Insurance Company 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 # _____

Employer's 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: _____

COVID Screening Completed: _____ Temp: _____

Signature of Dental Employee: _____