Community Health Center of the North Country

School Based Dental Home Program (SBDHP) Enrollment Form 2023-2024

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

Student's School: _____ Grade: ____ Teacher: _____

The dental screening and sealants are FREE of charge to all children with or without dental insurance.

In order for this program to remain sustainable, if your child has dental insurance we are required to bill the dental insurance. This enrollment form & consent will include follow up screenings as needed through June 30, 2024.

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) 386-8119.

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 SBDHP 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 ☐ Yes ☐ No

My child regularly goes to a dentist ☐ Yes ☐ No

Name & Address of Dentist: _____

Date of child's last preventative dental appointment: _____

I want treatment information forwarded to my child's regular dentist ☐ Yes ☐ No

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 Community Health Center of the North Country's SBDHP. 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)

Mailing Address: _____ _____ ____ _____
(Address) (City) (State) (Zip)

Date of Birth: _____ Student's Birth 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: _____ _____ ____ _____
(Address) (City) (State) (Zip)

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

Employer: _____ Work Phone: _____

Parent/Guardian Name: _____ DOB: _____

Relationship to Student: _____

Mailing Address: _____ _____ ____ _____
(Address) (City) (State) (Zip)

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

☐ No Dental Coverage

☐ Yes, My Child has Dental Coverage

In order for this program to remain sustainable, if your child has dental insurance we are required to bill the dental insurance. You will **NOT** be charged if treatment is not covered or is only partially covered. If you do receive a bill, please call our billing department at (315) 379-8121.

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: _____

Policy/Member ID # _____ Group # _____

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: _____

Employer's Name: _____

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 ☐ ADD/ ADHD ☐ Mental Health ☐ Diabetes ☐ Seizures ☐ Fainting
☐ Hepatitis ☐ Heart Murmur ☐ HIV/AIDS ☐ Intellectual or Developmental Disability
☐ Other _____

Does your child have any allergies (food, drug, environmental)? ☐ Yes ☐ No
If yes, describe: _____

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: _____

Biannual Screening Required: ☐ Yes ☐ No

Dietary Counseling & Anticipatory Guidance Provided: ☐ Yes ☐ No

Health Screening Completed: ☐ Yes ☐ No

Signature of Dental Employee: _____