BURLINGTON SCHOOL DISTRICT

6th thru 12th Grade

School-Based Dental Center

Medical/Dental History Form

6 Archibald St., Burlington, VT 05401 ■ IAA Tel: 658-4869 ■ Tel: 652-1050 ■ Fax: 652-1056

1. The Community Health Centers of Burlington (CHCB) offers a great kid's School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School, 6 Archibald Street, Burlington.
2. All children who are Burlington School District students or siblings of students, who are enrolled in Medicaid, Dr. Dynasaur or are low-income and uninsured AND have not seen a dentist in the past year, are welcome. If you are low-income and uninsured, CHCB will help you meet with our Patient Support Services staff to apply for programs and/or our Sliding-Fee Scale Program.
3. Just fill out this form and sign it (read the back for translation if needed) and send it back to the school. If you need help with this process, CHCB will help you fill out the form. Please contact your school nurse, school liaison, or CHCB's Dental Center at 652-1050 or 658-4869. Please check box that applies.

Once your child is signed up, the school and the Community Health Centers will take care of everything else for you. If your child does not attend the Integrated Arts Academy at H.O. Wheeler, transportation can be arranged. Remember, parents are always invited to dental appointments, too. Dental care for your child has never been so easy!

Please make sure you fill out the form **completely** and **sign it on each page.**
Each child needs a registration form. For another form, just call the Integrated Arts Academy at 658-4869 or CHCB's Dental Center's main telephone number 652-1050.

Today's Date ____/____/____ School Child Attends: ____________________

Child's Name: __________ (Last) __________ (First) ____ (MI) **Child's Date of Birth:** __/ ___/ ___

Child's Social Security Number: ____/____/____ **Primary Language:** __________

Street Address: __________ City __________ State ____ Zip Code ________

Name of Child's Physician: __________ Phone number __________ Last Visit ____

Name of Child's Dentist: __________ Phone number __________ Last Visit ____

Race	**Gender**	**Sexual Orientation**	**Legal Sex**	**Ethnicity/ Ethnic Origin**
☐ African-American	☐ Male	☐ Lesbian or Gay	☐ Male	☐ Hispanic
☐ Asian-American	☐ Female	☐ Straight/Heterosexual	☐ Female	☐ Non-Hispanic
☐ Caucasian/White	☐ Transgender Male	☐ Bisexual		
☐ Native American	☐ Transgender Female	☐ Something Else		
☐ Pacific Islander	☐ Other	☐ Don't Know		
☐ Multi-Racial	☐ Do Not Wish To Report	☐ Do Not Wish To Report		

Parent/Guardian Information

Name of Person Legally Responsible for Child: __________ Relationship: ________
Home # ______ Work # ______ Cell # ______ Email: ________

Alternate Contact Person: __________ Home # ______ Work # ______

Cell # __________ Relationship: ________ Email: ________

Insurance Information Does your child have Medicaid or **NO** insurance? Please explain.

____

☐ **Dr. Dynasaur/Medicaid Number #** ____________ ☐ **No Dental Insurance**

____

(Signature of parent/guardian) (Date)

☐ Interpretation or Translation offered and understood.

____

(Signature of person completing form if not parent/guardian) (Contact number)

Student's Name:____ Student's Date of Birth: ____________
(Last) (First) (MI)

Medical/Dental History Form

Your student's overall health as well as any medications that your student takes could have an important impact on your student's medical/dental care. **Please answer each of the following questions completely.**

Medical History

Does your student have any of the following diseases or problems? If **YES** please check the corresponding box:

Yes	No		Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Allergies	☐	☐	Anemia
☐	☐	Cancer	☐	☐	Congenital Heart Defect	☐	☐	Rheumatic Fever
☐	☐	Hepatitis	☐	☐	Convulsions/Epilepsy	☐	☐	Handicap/Disability
☐	☐	HIV/AIDS	☐	☐	Tuberculosis	☐	☐	Heart Murmur Antibiotic needed per Dr. ______________
☐	☐	Hemophilia	☐	☐	Abnormal Bleeding	☐	☐	ADHD
☐	☐	Diabetes	☐	☐	Sinus Trouble	☐	☐	Austism Spectrum

Other Health Questions about your student's habits and concerns.

	Yes	No		Yes	No
Does your student smoke tobacco products? How much? ____________________	☐	☐	Does your student use recreational drugs?	☐	☐
			Does your student use alcohol?	☐	☐
Are they interested in quitting?	☐	☐	Is your student pregnant or think they could be pregnant?	☐	☐
Do they have questions about smoking or other drug use?	☐	☐	Does your student have any sores in their mouth that concern them?	☐	☐
Does your student have any dental or health concerns or questions that they would like to talk about?	☐	☐	Does your student have any safety concerns at home or with friends?	☐	☐
Has your student ever been told they need antibiotics prior to dental work?	☐	☐	Has your student had any trouble with previous dental work?	☐	☐

Is your student **allergic** to or had a bad reaction from any of the following? If **YES** please check the corresponding box:

Yes	No		Yes	No		Yes	No	
☐	☐	Local anesthetics (Novocain)	☐	☐	Codeine or other narcotics	☐	☐	Iodine
☐	☐	Latex	☐	☐	Penicillin or other antibiotics	☐	☐	Other:
☐	☐	Aspirin	☐	☐	Sedatives, barbituarates, or sleeping pills	☐	☐	

Any other medical problems not listed (Please Explain):

____

List any medications your student is taking (Please include prescription and non-prescription drugs)

1.______________________________2.______________________________3.______________________________

Please sign below to ensure proper dental/ health care for your child. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to notify the healthcare provider office of any changes in my child's medical history. I also authorize treatment such as radiographs, routine check-ups (including fillings and extractions) and fluoride to be given to my child as needed at each dental visit.

____
(Signature of parent/guardian) (Date)

☐ Interpretation or Translation offered and understood.

____
(Signature of person completing form if not parent/guardian) (Contact number)

Student's Name:____ Student's Date of Birth: ___________
(Last) (First) (MI)

Medical/Dental History Form

Must be completed in advance of participation in the School-Based Dental Center

Consent to the Provision of Services

I authorize CHCB to see my child at the School-Based Dental Center:

- ☐ Whenever my child needs dental care
- ☐ Only when I have given specific written permission (except in the case of a medical, dental or behavioral health emergency)
- ☐ Only when I am present (except in the case of a medical, dental or behavioral health emergency)

Emergency Contact/Changes in Health Status or Custody

I further agree that I will promptly inform the School-Based Dental Center staff in writing of
1) any change in my child's physical or dental health and
2) any change in the custody or guardianship of my child which affects my ability to provide this Consent on behalf of my child.

Agreement Concerning Transportation to and from the School-Based Dental Center at the Integrated Arts Academy at The H.O. Wheeler School

Dental services for elementary, middle school and high school students are provided at the School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School. The State of Vermont has contracted with SSTA to provide transportation services for Medicaid eligible students to and from Burlington's schools and the School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School.

a) If my child needs transportation as indicated below, I consent to having CHCB schedule SSTA transportation to take my child to and from the H.O. Wheeler School for dental services, at no cost to me. CHCB may disclose information about my children's need for transportation and payment purposes.

b) I agree that SSTA may seek reimbursement from Medicaid for such transportation services.

If My Child is Seen at the End of the School Day, My Child:

- ☐ Should be transported home.
- ☐ May leave under their own supervision.
- ☐ May walk home with their siblings named ______________________________________
- ☐ May walk home with a friend(s) named ____
- ☐ Should be transported to babysitter / child care provider named _____________________ _

  located at ____________________ with this telephone number _____________________
- ☐ Should be transported home and dropped only if one of these adults is present:

  ____

I (parent or guardian name), ________________________________have read the above material and understand its meaning. My signature below is an acknowledgment that I have reviewed this form, understand the information and consent to all of the actions described above. My signature also attests to the accuracy of the information provided on both sides of this form.

____ __________
(Signature of parent/guardian) (Date)

☐ Interpretation or Translation offered and understood.

____ __________
(Signature of person completing form if not parent/guardian) (Contact number)

Student's Name:____ Student's Date of Birth: ____________
(Last) (First) (MI)

Medical/Dental History Form

Consent to Treatment and Consent to Release of Health Information

for Treatment, Payment and Health Care Operations

I. Consent to Treatment

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Community Health Centers of Burlington, Inc. (CHCB). Treatment may include health screening, diagnosis, medical treatment, dental care; social services; and/or mental health and drug and alcohol screening, assessment, diagnosis and treatment. I further understand this Consent covers only dental services provided at the School-Based Dental Center at the Integrated Arts Academy at H.O. Wheeler School and at the Community Health Centers of Burlington (CHCB). I understand CHCB will protect the privacy of my child's health and educational records to the extent required by federal and state law. I understand that a picture of my child will be taken for identification purposes only and kept within CHCB Records.

II. Consent to Release of Health Information, including Health/Treatment Records for Treatment, Payment and Health Care Operations

I consent to the use within CHCB and the disclosure to persons or organizations outside of CHCB of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health and other treatment and health records and information (such health records and information are referred to in this Consent as my "Health Information") by CHCB for the following purposes:

A. Use of Health Information By or For CHCB for Treatment and for Health Care Operations:

- Providing treatment by CHCB staff;
- Conducting health care operations of CHCB including, for example, financial or quality assurance audits and training.

B. Disclosure of Health Information to Persons Outside CHCB for Treatment Purposes and for Payment

- Providing all necessary Health Information as determined by CHCB, including information about treatment for drug or alcohol abuse, to any of the following health providers if I am referred there for treatment: University of Vermont Medical Center, Allergy & Asthma Associates, Champlain Valley Foot & Ankle, Associates in Orthopedic Surgery, Appletree Bay Physical Therapy, Four Seasons Dermatology, Evolution Physical Therapy & Yoga, Hand Surgery Associates, Green Mountain Physical Therapy, or the Rehab Gym.
- Providing Health Information to other health providers or agencies not listed above who may be involved in my care (except for information concerning treatment for drug or alcohol abuse for which a separate consent is required);
- Obtaining payment for health care bills, including sending such Health Information as is needed to secure payment for CHCB services to the insurance company, worker's compensation company or agency that pays for my health services, as identified in my CHCB Registration form or other updated insurance information on file with CHCB.
- School-Based Dental Program may share treatment and health information with Burlington School District social workers, school health personnel, counselors, principal, SSTA and Community Health Centers of Burlington (CHCB).

III. Other Matters

I understand that I have the right to revoke this Consent at any time, but revoking this Consent will not affect any actions which were taken by CHCB in reliance on this Consent before I revoked it. If not previously revoked, this consent will terminate on the following date, event, or condition: __________________________. If none is indicated, this consent will terminate three years after the last date of services to me.

I understand that I may request restrictions on use or disclosure of my Health Information for the purposes described in this Consent and that CHCB may or may not agree to the requested restrictions. I also understand that except for those restrictions on use or disclosure of Health Information to which it agrees, CHCB will not be able to provide services to me (or the named patient) without this signed Consent.

____ ____
(Signature of parent/guardian) (Date) (Signature of dentist reviewing history) (Date)

☐ Interpretation or Translation offered and understood.

____ ____________________
(Signature of person completing form if not parent/guardian) (Contact number)

Student's Name:____ Student's Date of Birth: ____________
(Last) (First) (MI)

Medical/Dental History Form

I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at CHCB.

I understand that, to the best of my knowledge, the demographic information I have provided is true and correct.

I have read the Consent to Treatment & Consent to Release of Health Information and I understand and consent to its content.

I hereby acknowledge that I have been offered a copy of CHCB's Payment Expectations document and understand and agree to adhere to these expectations.

Assignment of Benefits
I hereby assign to CHCB any and all payments to which I am entitled under Medicaid or any health insurance policy for health care, behavioral health, or dental health services rendered to me by CHCB as long as the charges for services by CHCB do not exceed CHCB's regular charges. I further authorize CHCB to bill and receive payment directly from Medicaid or my insurance carrier(s) for those services that CHCB delivered and for which I may be entitled to insurance coverage. I also authorize CHCB to give Medicaid or my health insurance carrier(s) any information necessary for billing purposes for services provided for such periods of time as I have received or am receiving primary health care, behavioral health, or dental health services.

Patients at the Community Health Centers of Burlington consent to disclosure of information for purposes of treatment, payment, and health care operations. Patient may consent to receipt or disclosures of health care information for other purposes as well.

Patients requesting information in regards to drug and alcohol counseling/treatment need to complete a separate authorization. No drug and alcohol information will be given without this permission.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand how CHCB may and may not use my protected health information in accordance with privacy law.

I understand that the Community Health Centers of Burlington, Inc may use any e-mail address or mobile phone number provided to contact me for appointment reminders or other announcements.
E-mail addresses and mobile phone numbers will not be sold to a third party or used for marketing purposes.

How did you hear about us? ☐ **Parent/Friend** ☐ **School Nurse** ☐ **Tooth Tutor** ☐ **CHCB Referral**

Name of Patient:____ Date of Birth ____________________

Patient Signature:____ Date: ________________________

Parent/Guardian: ____

Parent/Guardian Signature:__________________________________ Date:________________________

☐ Interpretation or Translation offered and understood.

____ ________________
(Signature of person completing form if not parent/guardian) (Contact number)

Student's Name:____ **Student's Date of Birth:** ____________
(Last) (First) (MI)

Important Information About Silver Diamine Fluoride

Silver Diamine Fluoride (SDF): Is an antibiotic liquid. We apply it to teeth to help STOP tooth decay. SDF causes the decay to turn black; ONLY THE DECAYED area will turn black. Healthy tooth structure will not be affected. In some cases the tooth may not require any additional dental treatment.

Benefits of using SDF:

- Patient does not need to get a shot, no numbing medicine needed! Application of SDF is painless as it is brushed onto the tooth surface just like regular fluoride!
- Painless and easy to apply!

Disadvantages of SDF:

- Stains location of decay a "black/brown" color.
- Most effective with multiple applications.
- The teeth treated may still need routine dental treatment in the future (fillings, extraction) depending on the extent of decay.

I am the Parent/Guardian of: **Name**________________________________ **DOB**___________. I have read the above information and understand its meaning.

My signature below is an acknowledgement that I have reviewed this form, understand the information, and consent to all of the actions listed above. My signature also attests to the accuracy of the information provided on this form.

Signature of Parent/Guardian______________________________Date__________________