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 (CHC) offers a great kid's School-Based Dental Center at the Integrated Arts Academy at (IAA), 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 are welcome. If you are low-income and uninsured, CHC will help you meet with our Patient Support Services staff to apply for programs and/or our Sliding-Fee Scale Program.
3. Please fill out this form and sign it and send it back to the school. If you need help with this process, CHC will help you fill out the form. Please contact your school nurse, school liaison, or CHC's Dental Center at 652-1050. 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 IAA, transportation can be provided. Remember, parents are encouraged to attend their child's dental appointments. For questions about dental services or to reschedule a dental appointment call 24 hours prior to appointment time at IAA, 802-652-1050.

Please make sure you fill out the form **completely** and **sign it on each page.**
Each child needs a separate registration form. For another form, please call the Integrated Arts Academy at 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	Do Not wish To Report		
Pacific Islander	Other			
Multi-Racial	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)

Community Health Centers

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			Seizure/Epilepsy			Handicap/Disability
		HIV/AIDS			Tuberculosis			Heart Murmur Antibiotic needed per Dr. _____
		Hemophilia			Abnormal Bleeding			ADHD
		Diabetes			Sinus Trouble			Autism Spectrum

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

	Yes	No		Yes	No
Does your student smoke tobacco products? How much? _____ Are they interested in quitting?			Does your student use recreational drugs? Does your student use alcohol?		
			Is your student pregnant or think they could be pregnant?		
*Are they taking any medications (Prescription or other) ? **See below**			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 or sleeping pills			

***List all 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.

_____
(Signature of parent/guardian) (Date)

Interpretation or Translation offered and understood.

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

Community Health Centers

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 CHC 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

Dental services for elementary, middle school and high school students are provided at the School-Based Dental Center at the Integrated Arts Academy. 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.

a) If my child needs transportation as indicated below, **I consent to having CHC schedule SSTA transportation to take my child to and from the IAA School for dental services, at no cost to me.** CHC 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.
- ☐ If at least 16 years of age, may leave and walk home under their own supervision.

-

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)

Community Health Centers

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. (CHC). 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. Dental services include: Exams, x-rays, dental cleanings, fluoride application, sealants, fillings, extractions and pulp therapy (primary teeth only), and application of silver diamine fluoride (see attached letter). I further understand this consent covers only dental services provided at the School-Based Dental Center at the Integrated Arts Academy and at the Community Health Centers of Burlington (CHC). I understand CHC 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 CHC 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 CHC and the disclosure to persons or organizations outside of CHC 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 CHC for the following purposes:

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

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

B. Disclosure of Health Information to Persons Outside CHC for Treatment Purposes : CHC is authorized to provide all necessary health information as determined by CHC, including information about treatment for drug or alcohol abuse, to any of the following health providers if I am referred there for treatment. Hospitals: University of Vermont Medical Center (UVMMC), Copley Hospital, Porter Hospital, Northwestern Medical Center, Central Vermont Medical Center (CVCA), Dartmouth Hitchcock Medical Center (DHMC). Allergy:Timberlane Allergy & Asthma Associates, Audiology: Adirondack Audiology Associates • Cardiology: CVCA, Central VT Cardiology, NWMC Cardio, DHMC Cardiology • Dermatology: Dorset St. Dermatology, Four Seasons Dermatology • Gastroenterology: VT Gastroenterology, Northwestern Medical Center • Home Health: Bayada Home Health, UVMMC Home Health & Hospice • Neurology: DHMC Neurology, Neurological Associates of Burlington • OB/GYN: Lake Champlain Gynecology, Maitri, VT Gynecology • Ortho: NWMC Ortho, Mansfield Ortho • Oximetry: Lincare • Pain Clinic: VT Interventional Spine Center, VT Pain Management, UVMMC Pain Management • Radiology: CVMC Radiology, NWMC, Porter, Copley and VT Open MRI • Sleep Study: VT Medical Sleep Disorder, UVMMC Sleep Program • Urology: DHMC Urology, Green Mountain Urology • Veterans Veterans Administration Programs and Facilities • Physical Therapy:(PT) PT 360, All Wellness PT, Appletree Bay, Catamount PT, Champlain PT, Choice PT, Cornerstone PT, DEE PT, Edge PT, Elite Health & Wellness, Essex PT, Every Woman, Evolution Therapy & Yoga, Excel PT, Fairfax PT, Forever Fit, Genesis PT, Green Mtn. PT, Injury & Health Management Solutions, Inspire PT, Island PT, Living Well Center for Integrated Health, Long Trail PT, On Track PT, Peak PT, Pelvic Health, Phoenix PT, Pinnacle PT, Rehab Gym, Transitions PT, Timberlane PT, Vasta PT, and Vermont PT. 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.

III. Termination and restrictions of this consent:

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 CHC 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 CHC 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, CHC will not be able to provide services to me (or the named patient) without this signed consent.

IV. **Assignment of Benefits:** I hereby assign to CHC any and all payments to which I am entitled under Medicaid, Medicare, or any health insurance policy for health care, behavioral health, psychiatry or dental health services rendered to me by CHC. I further authorize CHC to bill and receive payment directly from Medicaid /Medicare or my insurance carrier(s) for those services that CHC delivered and for which I may be entitled to insurance coverage. I also authorize CHC 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 health screening, diagnosis ,medical treatment, dental care, social services, mental health. I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at CHC.

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

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

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand how CHC 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.

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

How did you hear about us?

- ☐ **Parent/Friend**
- ☐ **School Nurse**
- ☐ **Tooth Tutor**
- ☐ **CHC 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)

Community Health Centers

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:

- 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 consent to the use of SDF as prescribed by the CHC provider:

Yes_____ No_____

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

Signature of Parent/Guardian_____Date_____