Somali

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)

Dentist Initials: _____

Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan

Foomka Taariikhda Caafimaadka/Daryeelka Ilkaha

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

1. Xarumaha Caafimaadka Bulshada (CHC) waxay bixiyaan Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan oo u wanaagsan ilmaha oo ku taal Integrated Arts Academy ee (IAA), 6 Archibald Street, Burlington.
2. Dhamaan caruurta ah ardayda Degmado Dugsiga Burlington ama ardayda walaalahood, ee ku jira Medicaid, Dr. Dynasaur ama kuwa dakhligoodu hooseeyo ee aan caymiska lahayn way iman karaan. Hadii aad dakhli hooseeyo oo aad bilaa caymis tahay, CHC waxay kaa caawin doontaa inaad la kulanto shaqaalaheena Adeegyada Taageerada Bukaanka si aad u dalbato barnaamijyada iyo/ama Barnaamijka Kordhinta Bilaashka ah ee Socota.
3. Fadlan buuxi foomkan oo saxeex oo u soo dir dugsiga. Hadii aad u baahan tahay in lagaa caawiyo nidaamkan, CHC waxay kaa caawin doontaa buuxinta foomka. Fadlan kala xidhiidh kaaliyaha dugsigaaga, wakiilka dugsiga, ama Xarunta Daryeelka Ilkaha CHC 652-1050. Marka ilmahaaga la duwaan geliyo, dugsiga iyo Xarumaha Caafimadka Bulshada ayaa waxa kale oo dhan kaa dabari doona. Hadii aanu ilmahaagu dhigan IAA, gaadiid ayaa lasiin doonaa. Xasuuso, waalidiinta waxaa lagu dhiiri gelinayaa inay balanta u soo raacaan daryeelka ilkaha ilmaha. Wixii su'aalo ah ee ku saabsan adeegyada daryeelka ilkaha ama inaad dib u qabsato balanta daryeelka ilkaha kala hadal 24 saacadood kahor wakhtiga IAA, 802-652-1050.

Fadlan xaqiiji inaad foomka **buuxiso** oo **aad saxeexdo bog kasta.**
Ilmo kasta waxa uu u baahan yahay foom gaar ah oo is duwaan gelin ah. Wixii foom kale ah, fadlan kala hadal Integrated Arts Academy 652-1050.

Taariikhda Maanta ____/____/____ Dugsiga Ilmuhu Dhiganayo: _____

Magaca Ilmaha:_____ _____ _____ **Taariikhda Dhalashada Ilmaha:**____/ ____/_____
(Awowga) (Kowaad) (Aababa)

Lambarka Sooshaal Sekuuritiga Ilmaha: _____/_____/_____ **Luuqada Kowaad:** _____

Cinwaanka Jidka: _____Magaalada_____Gobolka_____Boosta _____

Magaca Dhakhtarka Ilmaha: _____ Lambarka taleefanka _____Booqashada Ugu Danbaysay _____

Magaca Dhakhtarka Ilkaha Ilmaha: _____ Lambarka taleefanka_____Booqashada Ugu Danbaysay _____

Isir	**Jinsi**	**Rabitaanka Jinsiga**	**Jinsiga Sharciga ah**	**Qoomiyad/**
Maraykan Madaw	Lab	Khaniis ama Khaniisad	Lab	**Qoomiyada Uu Kasoo Jeedo**
Aasiyaan Maraykan ah	Dhedig	Jinsi Caadi ah	Dhedig	Hisnaabig
Cadaan	Nin Jinsiga Badalay	Labeeb		Aan Hisbaanig Ahayn
Dhalad Maraykan	Gabadh Jinsiga Badashay	Ma Doonayo inaan Sheego		
Jasiirada Baasifiga	Waxkale			
Iska Dhal	Ma Doonayo Inaan Sheego			

Macluumaadka Waalidka/Koriyaha

Magaca Qofka Sida Sharciga Ah Uga Masuulka ah Ilmaha: _____ Xidhiidhka: _____
Lambarka Guriga _____Lambarka Shaqada _____Lambarka Taleefanka_____Iimeel: _____

Macluumaad Xidhiidh Oo Shakhsi Ahaaneed oo Kale: _____ Lambarka Guriga _____Lambarka Shaqada _____

Lambarka Taleefanka_____Xidhiidhka: _____ Iimeel: _____

Macluumaadka Caymiska Miyaa ilmahaagu haystaa Medicaid ama **BILAA** caymis yahay? Fadlan sharax.

_____

Lambarka Dr. Dynasaur/Medicaid _____ **Malaha Caymiska Daryeelka Ilkaha**

_____
(Saxeexa waalidka/koriyaha) (Taariikhda)

Turjubaad ama Turjun ayaa la bixiyay oo la fahmay.

_____
(Saxeexa qofka buuxinaya foomkan hadii aanu ahayn waalid/koriye) (Macluumaadka xidhiidhka)

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

Magaca Ardayga:_____ **Taariikhda Dhalashada Ardayga:** _____
(Awo (Kowa (Aa

Foomka Taariikhda

Caafimaadka guud ee ardayga iyo sidoo kale wixii dawooyin ah ee ardaygaagu uu qaato ee saamaynta wayn ku leh daryeelka caafimaad/ilko ardaygaaga. **Fadlan ka jawaab su'aal kasta oo kamid ah kuwa soo socda.**

Taariikhda Caafimaadka

Miyuu ardaygaagu qabaa wax kamid ah xanuunada ama mushkiladaha so socda? Hadii **HAA** tahay fadlan sax sanduuqa ku haboon:

Haa	Maya		Haa	Maya		Haa	Maya	
		Xiiq			Xasaasiyad			Dhiig yaraan
		Kaansar			Xanuun Wadnaha ah			Xumad Badan
		Joonis			Suuxdin/Dhicid			Laxaad La'aan
		HIV/Aydhis			Qaaxo			Murmur Wadnaha ah Antiboodhi u baahday Dr. _____
		Hemophilia			Dhiigid Aan Caadi Ahayn			ADHD
		Macaan			Mushkilad Sanboor			Autism Spectrum

Su'aalaha Kale ee Caafimaad ku saabsan habdhaqankaaga caafimaadka iyo walaacyada.

	Haa	Maya		Haa	Maya
Miyaa ardaygaagu cabaa sigaar? Intee in le'eg? _____			Miyaa ardaygaagu isticmaalaa mukhaadaraad? Miyaa ardaygaagu cabaa khamri?		
Ma doonayaa inuu joojiyo?			Miyaa ardaygaagu leeyahay uur ama doonayaa inuu uur qaado?		
*Miyuu qaataa dawooyin (Loo qoray ama kale) ? **Ka eeg hoos**			Miyaa ardaygaagu ku leeyahay wax barar ah afkiisa oo aad ka warwarto?		
Miyaa ardaygaagu qabaa wax mushkilad ilkaha ama walaacyo ama su'aalo ay doonayaan inay ka hadlaan?			Miyaa ardaygaagu qabaa wax walaacyo amaan ah oo guriga ah ama asxaabtii marka uu la joogo?		
Miyaa ardaygaaga weli loo sheegey inuu u baahan yahay antiboodhi kahor inta aan loo fidin daawaynta ilkaha?			Miyaa ardaygaagu wax mushkilad ah kala kulmay shaqada daryeelka ilkaha?		

Miyaa ardaygaagu **xasaasiyad** ka qaadaa ama jawaab celin xun ka leeyahay waxyaabaha soo socda? Hadii **HAA** tahay fadlan sax sanduuqa ku haboon:

Haa	Maya		Haa	Maya		Haa	Maya	
		Suuxdinta deegaanka (Novocain)			Codeine ama mukhaadaraadka kale			Ayodhiinta
		Cinjirka			Beensaliin ama antiboodhiga kale			Waxkale:
		Asbiriin			Suuxdin ama kiniinka hurdada			

***Qor dhamaan dawooyinka ardaygaagu qaato (Fadlan waxa aad ku dartaa dawooyinka la qoro iyo dawooyinka aan la qorin):**

1._____ 2._____ 3._____

Fadlan saxeex hoos si aad u xaqiijiso daryeelka ilkaha/caafimaad oo haboon inuu helo ilmahaagu. Ilaa inta aan ogahay, su'aalaha ku qoran foomkan waxa aan uga jawaabay si sax ah. Waxa aan ogahahay in bixinta macluumaad khaldan ay khatar u tahay caafimaadka ilmahayga. Aniga ayaa ka masuul ah inaan wargeliyo xafiiska bixiyaha caafimaadka wixii isbadalo ah ee ku yimaada taariikhda caafimaadka ilmahayga.

(Saxeexa waalidka/koriyaha) (Taariikhda)

Turjubaad ama Turjun ayaa la bixiyay oo la fahmay.

(Saxeexa qofka buuxinaya foomkan hadii aanu ahayn waalid/koriye) (Macluumaadka xidhiidhka)

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)

Magaca Ardayga: _____ **Taariikhda Dhalashada Ardayga:** ____
(Awo (Kowa (Aa

Foomka Taariikhda

Waa in la buuxiyaa kahor ka qayb galka Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan

Ogolaanshaha Bixinta Adeegyada

Waxa aan u ogolaaday CHC inay ku aragto ilmahayga Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan:

- ☐ Markasta oo ilmahaygu u baahdo daryeelka ilkaha
- ☐ Kaliya marka aan bixiyo ogolaanshe qoraal ah oo gaar ah (marka laga tago kiiska caafimaad, ilkaha ama habdhaqanka ee caafimaadka degdega ah)
- ☐ Kaliya marka aan joogo (marka laga tago kiiska caafimaad, ilkaha ama habdhaqanka ee caafimaadka degdega ah)

Macluumaadka Xidhiidhka Xaalada Degdega ah ee Xaalada Caafimaadka ama Xadhiga
Waxa aan sidoo kale ogolaaday in aan si dhakhso ah ugu sheego shaqaalaha Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan iyada oo qoraal ah
1) wixii isbadal ah ee caafimaadka jidhka ama ilkaha ee ilmahayga ku yimaada iyo
2) wixii isbadal ah ee gacan ku haynta ama korinta ilmahayga ee saamayn kara awoodayda in aan u bixiyo ogolaanshahan ilmahayga.

Heshiiska Ku Saabsan Gaadiidka ee lagu imanayo iyo lagaga tagayo Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan ee Integrated Arts Academy
Adeegyada daryeelka ilkaga ee ardayda dugsiga hoose, dhexe iyo sare waxaa lagu bixiyaa Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan ee Integrated Arts Academy. Gobolka Vermont waxa uu qandaraas ku siiyay SSTA inay siiso adeegyada gaadiidka ardayda u qalantan Medicaid ee ay ku imanayaan iyo kaga tagayaan dugsiyada Burlington iyo Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan ee Integrated Arts Academy.

a) Hadii ilmahaagu uu u baahan yahay gaadiid sida lagu sheegey hoos, **waxa aan ogolaaday in aan balan ka qabsado CHC gaadiidka SSTA ah si ay ilmahayga u geeyaan oo ay uga keenaan Dugsiga IAA ee adeegyada ilkaha, iyada oo bilaash ah.** CHC waxay u bixin karaan macluumaadka caruurtayda wixii baahida gaadiidka iyo wixii ujeedo lacageed ah.
b) Waxa aan ogolaaday in SSTA ay ka dalban karto gudid lacageed Medicaid wixii adeegyada gaadiidka ah.

Hadii Ilmahayga La Arko Dhamaadka Maalinta Dugsiga, Ilmahayga:

- ☐ Waa in la geeyaa guriga.
- ☐ Hadii ay yihiin ugu yaraan 16 jir, waa la iskaga tegi karaa oo guriga ayay tegi karaan iyada oo ayna cidna la socon.

Aniga oo ah (waalidka ama koriyaha magiciisa kor lagu sheegey), _____waxa aan akhriyay macluumaadka sare oo waxa aan fahmay waxay ka dhigan yihiin. Saxeexayga hoose waa qiraal in aan akhriyay foomkan, fahmay macluumaadka, oo waxa aan ogolaaday dhamaan talaabooyinka ku qoran sare. Saxeexaygu waxa uu sidoo kale muujinayaa saxnaanta macluumaadka ku qoran foomkan labada dhinacba.

_____ _____
(Saxeexa waalidka/koriyaha) (Taariikhda)

Turjubaad ama Turjun ayaa la bixiyay oo la fahmay.

_____ _____
(Saxeexa qofka buuxinaya foomkan hadii aanu ahayn waalid/koriye) (Macluumaadka xidhiidhka)

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

Community Health Centers

Magaca Ardayga:_____ **Taariikhda Dhalashada Ardayga:** ____
(Awo (Kowa (Aa

Foomka Taariikhda

Ogolaanshaha Daawaynta iyo Ogolaanshaha Bixinta Macluumaadka Caafimaad

ee Daawaynta, Lacag Bixinta iyo Shaqada Daryeelka Caafimaad

I. Ogolaanshaha Daawaynta

Waxa aan halkan ku ogolaaday daawaynta naftayda, ama bukaanka magiciisa la sheegey (oo aan anigu u ahay waalidkii ama koriyihiisa sharciga ah oo xaq u leh inuu u ogolaado daawaynta bukaanka magiciisa lagu sheegey kor) Xarumaha Caafimadka Bulshada ee Burlington, Inc. (CHC). Daawaynta waxaa kamid ah shaybaadhka, baadhitaanka iyo daawaynta caafimaad, daryeelka ilkaha; adeegyada bulshada; iyo/ama caafimaadka iyo/ama shaybaadhka caafimaadka maskaxda iyo khamrida, qiimaynta, xanuunka iyo daawaynta. Adeegyada daryeelka ilkaha waxaa kamid ah: Shaybaadhka, raajiga, nadiifinta ilkaha, marinta folooriinta, buuxinta, moorinta, ka saarida iyo daawaynta bulaab (kaliya ilmaha hore), iyo marinta folooriinta diamine ee jaandiga (ka eeg warqada lifaaqa). Waxa aan sidoo kale fahansanahay in ogolaanshahan kaliya uu khuseeyo adeegyada daryeelka ilkaha ee Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan ee Integrated Arts Academy iyo Xarumaha Caafimaadka Bulshada Burlington (CHC). Waxa aan fahansanahay in CHC ay ilaalin doonto sirta caafimaadka ilmahayga iyo duwaanada waxbarashada ilaa inta uu dhigayo sharciga federalka iyo gobolku. Waxa aan fahansanahay in sawirka ilmahayga laga qaadi doono wixii ujeedo aqoonsi kaliya oo lagu hayn doono Duwaanada CHC.

II. Ogolaanshaha Bixinta Macluumaadka Caafimaad, waxaa kamid ah Duwaanada Caafimaadka/Daawaynta ee Daawaynaha, Lacag Bixinta iyo Shaqada Daryeelka Caafimaadka: Waxa aan ogolaaday isticmaalka CHC iyo in la siiyo dad iyo hay'ado ka baxsan CHC duwaanadayda (ama kuwa bukaanka la sheegey magiciisa ee aan waalidka ama koriyaha u ahay) caafimaad, daryeelka ilkaga, khamrida iyo mukhaadaraadka, caafimaadka maskaxda iyo daawaynaha kale iyo caafimaadka iyo macluumaadka (sida duwaanada iyo macluumaadka caafimaad ee lagaga hadlay ogolaanshahan ee lagu sheegey "Macluumaadkayga Caafimaad") ee CHC wixii ah ujeedada soo socota:

A. Isticmaalka Macluumaadka Caafimaad ee ama Loogu Talo Geley CHC ee Wixii Daawayn iyo Shaqooyinka Daryeelka Caafimaadka:

- Bixinta daawaynta shaqaalaha CHC;
- Qabashada shaqooyinka daryeelka caafimaad ee CHC oo ay ku jiraan, tusaale ahaan, hantidhawrka dhaqaale ama tayada caymiska iyo tobobarka.

B. Siinta Macluumaadka Caafimaad ee Dad Ka Baxsan CHC wixii ah Ujeedo Daawayn: CHC waxaa loo ogol yahay inay u bixiso dhamaan macluumaadka caafimaadka daruuriga ah sida ay jidaysay CHC, oo uu ku jiro macluumaadka ku saabsan daawaynta balwadaha mukhaadaraadka ama khamrida, wixii kamid ah bixiyayaasha caafimaadka ee soo socda hadii la iigu gudbiyo daawayn. Isbitaalada: Xarunta Caafimaadka Jaamacada Vermont (UVMMC), Isbitaalka Copley, Isbitaalka Porter, Xarunta Caafimaadka Northwestern, Xarunta Caafimaadka Central Vermont (CVCA), Xarunta Caafimaadka Dartmouth Hitchcock (DHMC). Xasaasiyado: Xasaasiyada Looxa & Xiiqda La Xidhiidha, Dhagaha: Ururka Caafimaadka Dhagaha Adirondack • Wadnaha: CVCA, Isticmaalka Caafimaadka Waxnaha Central VT, Caafimaadka Wadnaha NWMC, Caafimaadka Waxnaha DHMC • Dermatology: Dorset St. Dermatology, Four Seasons Dermatology • Caloosha: Isbitaalka Caloosha VT, Xarunta Caafimaadka Northwestern • Caafimaadka Guriga: Caafimaadka Guriga Bayada, Caafimaadka Guriga UVMMC & Hospice • Neerfaha: Neerfaha DHMC, Ururka Neerfaha Burlington • OB/GYN: Dhakhtarka Dumarka Lake Champlain , Maitri, Dhakhtarka Dumarka VT • Ortho: NWMC Ortho, Mansfield Ortho • Oximetry: Lincare • Xarunta Caafimaadka Damqashada: Xarunta Lafdhabarta ee Caalamiga ah ee VT, Xakamaynta Damqashada VT, Xakamaynta Damqashada UVMMC • Shucaaca: Shucaaca CVMC, NWMC, Porter, Copley iyo VT Open MRI • Daraasada Hurdada: Khalkhalka Hurdada Caafimaad VT, Barnaamijka Hurdada UVMMC • Urology DHMC Urology, Green Mountain Urology • Xarumaha iyo Barnaamijyada Maamulida Ciidanka Hawl Gabay • Dabiibka Jidhka:(PT) PT 360, All Wellness PT, Appletree Bay, Catamount PT, Champlain PT, Choice PT, Cornerstone PT, DEE PT, Edge PT, Caafimaadka Badqabka Elite, Essex PT, Every Woman, Dabiibka Nafsiga iyo Yoogada, Excel PT, Fairfax PT, Forever Fit, Genesis PT, Green Mtn. PT, Xalalka Maamulida Dhaawaca iyo Caafimaadka, Inspire PT, Island PT, Xarunta Caafimaadka La Is Dhaxgeliyay Living Well, Long Trail PT, On Track PT, Peak PT, Caafimaadka Pelvic, Phoenix PT, Pinnacle PT, Jiimka Dib u Dejinta, U Wareega PT, Timberlane PT, Vasta PT, iyo Vermont PT. Lugta iyo Kuraanta Champlain Valley, Ururka Qaliinka Lafaha, Daawaynta Jidhka Appletree Bay, Four Seasons Dermatology, Dabiibka Jidhka & Yogada, Ururka Qaliinka Gacanta, Daawaynta Jidhka Green Mountain, ama Jiimka Dib u Dejinta.

III. Joojinta iyo xadidaada ogolaanshahan:

Waxa aan fahansanahay in aan xaq u leedahay in aan ka noqdo ogolaanshaha wakhti kasta, laakiin ka noqoshada ogolaanshahan ma saamaynayso wixii talaabooyin ah ee ay qaaday CHC ee ku salaysan ogolaanshahan kahor inta aan laga noqon. Hadii aan hore looga noqon, ogolaanshahan waxaa uu ku eeg yahay taariikhda, dhacdada, ama xaalada soo socota: _____. Hadii aan midna la sheegin, ogolaanshahan waxa uu ku eeg yahay **sadex sano** kadib taariikhda ugu danbaysa ee adeegyada la i siiyo. Waxa aan fahansanahay in aan dalban karo xadidaado isticmaalka ama bixinta Macluumaadkayga Caafimaad wixii ujeedo lagu sheegey ogolaanshahan iyo in CHC ay ogolaan karto ama ayna ogolaanaynin dalabka xadidaada. Waxa aan fahansanahay in marka laga tago wixii xadidaado ah ee isticmaal ama bixin Macluumaadka Caafimaad ee lagu heshiiyay, CHC inayna awoodin inay i siiso adeegyada aniga (ama bukaanka la magacaabay) hadii aan la saxeexin ogolaanshahan.

IV. **Ku Qorida Gunooyinka:** Waxa aan halkan ku qoray CHC dhamaan lacagaha aan xaqa u leedahay ee Medicaid, Medicare, ama wixii caymis caafimaad ee daryeelka caafimaad, caafimaadka habdhaqanka, dhakhtarka cilmi nafsi ama adeegyada caafimaadka ilkaha ee ay i siisay CHC. Waxa aan sidoo kale u ogolaaday CHC inay ku dalacdo oo ay ka qaadato lacagta si toos ah Medicaid/Medicare ama caymiskayga adeegyada ay CHC bixisay ee aan xaqa ugu leeyahay caymiska. Waxa aan u ogolaaday CHC inay siiso Medicaid ama caymiskayga caafimaadka wixii

macluumaad ee daruuri u ah ujeedada lacag dalicida adeegyada la i siiyay mudooyinka aan qaaday ama aan qaadanayo shaybaadhka caaifmaad, baadhitaanka, daawaynta caafimaad, daryeelka ilkaha, adeegyada bulshada, caafimaadka maskaxda.
Waxa aan fahansanahay oo aan qirayaa in dhaqaale ahaan aan ka masuul ahay wixii baaqi lacag ah ee aan galo ee daryeelkayga CHC.

Waxa aan fahansanahay in, ilaa inta aan ogahay, macluumaadka deegaanka ee aan bixiyay ay yihiin run oo sax yihiin.

Waxa aan halkan ku qirayaa in la i siiyay nuqul waraaqaha Sharaxaya Lacagta CHC oo aan fahmay oo aan ogolaaday in aan u hogaansamo filashooyinkan.

Waxa aan halkan ku qirayaa in la i siiyay nuqul Wargelinta Nidaamka Sirta oo aan fahmay sida CHC ay u isticmaali karto iyo u isticmaali karin macluumaadka caafimaadka la ilaaliyay si waafaqsan sharciga sirta.

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)

Magaca Ardayga: _____ **Taariikhda Dhalashada Ardayga:** ____
(Awo (Kowa (Aa

Foomka Taariikhda

Waxa aan fahanasanahay in Xarumaha Caafimadka Bulshada Burlington, Inc. ay isticmaali karto cinwaan iimeel ama lambar taleefanka gacanta oo ku qoran macluumaadkayga xidhiidhka wixii xasuusin balanta ama bayaanada kale ah. Cinwaanada iimeelka iyo lambarada taleefanka mobileka lagama iibin karo cid kale ama looma isticmaali karo wixii ujeedo suuqgayn ah.

Waxa aan akhriyay Ogolaanshaha Daawaynta & Ogolaanshaha Bixinta Macluumaadka Caafimaad oo aan fahmay oo ogolaadan ogolaanshaheeda.

Sidee macluumaadkaaga ku heshey?

- ☐ **Waalid/Saaxiib**
- ☐ **Kaaliyaha Caafimaadka Dugsiga**
- ☐ **Baraha Iliga**
- ☐ **Gudbinta CHC**

Magaca Bukaanka: _____ Taariikhda Dhalashada _____

Saxeexa Bukaanka: _____ Taariikhda: _____

Waalidka/Koriyaha: _____

Saxeexa Waalidka/Koriyaha: _____ Taariikhda: _____

Turjubaad ama Turjun ayaa la bixiyay oo la fahmay.

_____ _____
(Saxeexa qofka buuxinaya foomkan hadii aanu ahayn waalid/koriye) (Macluumaadka xidhiidhka)

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_____

Community Health Centers

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

Macluumaad Muhiim ah oo Ku Saabsan Silver Diamine Fluoride

Silver Diamine Fluoride (SDF): Waxaa weee dareere antibootig ah. Waxaanu marinaa ilkaha si aanu u JOOJINO inay yeeshaan suus. SDF waxay keentaa inay qaybt talooshantaa mdaw noqoto; KALIYAHA aaga DALOOSHAHA ayaa noqda madaw. Ilmaha caafimaadka qaba ma saamayn doono. Mararka qaar iligu uma baahdo daawayn ilkaha oo dheeraad ah.

Faa'idada istimcaalka SDF:

- Bukaanku uma baahdo irbad, iyo dawada suuxisada! Marinta SDF malaha xanuun maadaama oo burush lagu mariyo dusha iliga sida fluoride caadiga ah oo kale!
- Bilaa xanuun oo si fudud oo marin karo!

Faa'ido darasada SDF:

- Waxay wax tartaa marka dhawr jeer la mariyo.
- Ilkaha lagu daweeyaa waxay u baahan karaan daawayn joogto ah mustaqbalka (buuxin, saaritaan) taas oo ku xidhan heerka suusku.

Waxaan ahayn Waalidka/Koriyaha:

Magaca_____ **Taariikhda Dhalashada** _____

Waxaan ogolaaday isticmaalka SDF ee uu qoray bixiyaha CHC:

Haa_____ Maya_____

Saxeexa hoose waxa uu qirayaa in aan heley foomkan, fahmay

macluumaadka, oo aan ogolaaday dhamaan talaabooyinka ku qoray kor.

Saxeexa Waalidka/Koriyaha_____Taariikhda _____