



DATE REC/ENTERED:
STAFF INITIALS:

PATIENT REGISTRATION FORM

LOCATION: RIVERSIDE SAFE HARBOR PEARL STREET SOUTH END CHAMPLAIN ISLANDS GOOD HEALTH WINOOSKI ESSEX

As a Federally Qualified Health Center, CHC is required by the federal government to collect the following information. **Please note that all responses are confidential.**

PATIENT DEMOGRAPHICS (PLEASE FILL OUT ENTIRE FORM IN BLACK OR BLUE PEN ONLY)						
LAST NAME		FIRST NAME		MIDDLE INITIAL	CHOSEN NAME (IF ANY)	
STREET ADDRESS		CITY		STATE	ZIP CODE	
MAILING ADDRESS (IF DIFFERENT THAN PHYSICAL ADDRESS)						
SOCIAL SECURITY NUMBER			DATE OF BIRTH		PRONOUNS	
CELL PHONE			WORK PHONE		HOME PHONE	
EMAIL ADDRESS				PREFERRED CONTACT METHOD		
				<input type="checkbox"/> PHONE <input type="checkbox"/> TEXT <input type="checkbox"/> EMAIL <input type="checkbox"/> PATIENT PORTAL		
LEGAL SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	CURRENT GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	GENDER IDENTITY <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> TRANSGENDER MALE (FEMALE-TO-MALE) <input type="checkbox"/> TRANSGENDER FEMALE (MALE-TO-FEMALE) <input type="checkbox"/> GENDERQUEER <input type="checkbox"/> OTHER <input type="checkbox"/> CHOOSE NOT TO DISCLOSE			SEXUAL ORIENTATION <input type="checkbox"/> STRAIGHT OR HETEROSEXUAL <input type="checkbox"/> LESBIAN, GAY, OR HOMOSEXUAL <input type="checkbox"/> BISEXUAL <input type="checkbox"/> SOMETHING ELSE <input type="checkbox"/> DON'T KNOW <input type="checkbox"/> CHOOSE NOT TO DISCLOSE	
PRIMARY LANGUAGE			DO YOU NEED INTERPRETER SERVICES?			
			<input type="checkbox"/> YES <input type="checkbox"/> NO			
MARITAL STATUS		ARE YOU A U.S. VETERAN?		ARE YOU AN AGRICULTURAL WORKER?		
<input type="checkbox"/> SINGLE <input type="checkbox"/> SEPERATED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> CIVIL UNION		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> NO <input type="checkbox"/> MIGRANT <input type="checkbox"/> SEASONAL		
HOUSING STATUS						
ARE YOU HOMELESS? <input type="checkbox"/> YES <input type="checkbox"/> NO						
IF HOMELESS, ARE YOU: <input type="checkbox"/> DOUBLING UP (LIVING WITH OTHERS) <input type="checkbox"/> SHELTER <input type="checkbox"/> STREET <input type="checkbox"/> TRANSITIONAL <input type="checkbox"/> UNKNOWN						
RACE (SELECT ALL THAT APPLY)						
ASIAN	NATIVE HAWAIIAN OR PACIFIC ISLANDER		BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN OR ALASKA NATIVE	WHITE	CHOOSE NOT TO DISCLOSE
<input type="checkbox"/> CHINESE	<input type="checkbox"/> NATIVE HAWAIIAN		<input type="checkbox"/> BLACK OR AFRICAN AMERICAN	<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE	<input type="checkbox"/> WHITE	<input type="checkbox"/> CHOOSE NOT TO DISCLOSE
<input type="checkbox"/> VIETNAMESE	<input type="checkbox"/> OTHER PACIFIC ISLANDER					
<input type="checkbox"/> ASIAN INDIAN	<input type="checkbox"/> GUAMANIAN OR CHAMORRO					
<input type="checkbox"/> KOREAN	<input type="checkbox"/> SAMOAN					
<input type="checkbox"/> FILIPINO						
<input type="checkbox"/> JAPANESE						
<input type="checkbox"/> OTHER ASIAN						
ETHNICITY						
HISPANIC, LATINO/A, OR SPANISH ORIGIN			NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN		CHOOSE NOT TO DISCLOSE	
<input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> CHICANO <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> HISPANIC, LATINO/A, OR SPANISH ORIGIN <input type="checkbox"/> ANOTHER HISPANIC, LATINO/A, AND SPANISH ORIGIN			<input type="checkbox"/> NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN		<input type="checkbox"/> CHOOSE NOT TO DISCLOSE	

Patient Name:

Date of Birth:

FINANCIAL INFORMATION: PLEASE CIRCLE THE APPROPRIATE FAMILY SIZE AND CORRESPONDING HOUSEHOLD INCOME RANGE ON THE TABLE BELOW. ALL RESPONSES ARE CONFIDENTIAL.

2024 FEDERAL POVERTY GUIDELINES				
FAMILY SIZE	0-100% FEDERAL POVERTY LEVEL	101-150% FEDERAL POVERTY LEVEL	151-200% FEDERAL POVERTY LEVEL	OVER 200% FEDERAL POVERTY LEVEL
HOUSEHOLD ANNUAL INCOME RANGE BASED ON FAMILY SIZE				
1	\$0 TO \$15,060	\$15,061 TO \$22,590	\$22,591 TO \$30,120	\$30,121 & OVER
2	\$0 TO \$20,440	\$20,441 TO \$30,6060	\$30,661 TO \$40,880	\$40,881 & OVER
3	\$0 TO \$25,820	\$25,821 TO \$38,730	\$38,731 TO \$51,640	\$51,641 & OVER
4	\$0 TO \$31,200	\$31,201 TO \$46,800	\$46,801 TO \$62,400	\$62,401 & OVER
5	\$0 TO \$36,580	\$36,581 TO \$54,870	\$54,871 TO \$73,160	\$73,161 & OVER
6	\$0 TO \$41,960	\$41,961 TO \$62,940	\$62,941 TO \$83,920	\$83,921 & OVER
7	\$0 TO \$47,340	\$47,341 TO \$71,010	\$71,011 TO \$94,680	\$94,681 & OVER
8	\$0 TO \$52,720	\$52,721 TO \$79,080	\$79,081 TO \$105,440	\$105,441 & OVER
9	\$0 TO \$58,100	\$58,101 TO \$87,150	\$87,151 TO \$116,200	\$116,201 & OVER
10	\$0 TO \$63,480	\$63,481 TO \$95,220	\$95,221 TO \$126,960	\$126,961 & OVER
*	<i>*ADD \$5,380 PER EACH ADDITIONAL FAMILY MEMBER.</i>	<i>*ADD \$8,070 PER EACH ADDITIONAL FAMILY MEMBER.</i>	<i>*ADD \$10,760 PER EACH ADDITIONAL FAMILY MEMBER</i>	

DENTAL INSURANCE INFORMATION

- I currently have dental insurance.
- I currently DO NOT have dental insurance.
- I would like to apply for the sliding-fee scale.

DENTAL INSURANCE NAME:
POLICY/ID NUMBER:
POLICY HOLDER NAME:

SECONDARY DENTAL INSURANCE INFORMATION:
DENTAL INSURANCE NAME:
POLICY/ID NUMBER:
POLICY HOLDER NAME:

MEDICAL INSURANCE INFORMATION

- I currently have medical insurance.
- I currently DO NOT have medical insurance.
- I would like to apply for the sliding-fee scale.

MEDICAL INSURANCE NAME:
POLICY/ID NUMBER:
POLICY HOLDER NAME:

SECONDARY MEDICAL INSURANCE INFORMATION:
MEDICAL INSURANCE NAME:
POLICY/ID NUMBER:
POLICY HOLDER NAME:

PREFERRED PHARMACY

PHARMACY NAME **PHARMACY LOCATION**

EMERGENCY CONTACT INFORMATION

NAME **RELATIONSHIP** **PHONE NUMBER**

RESPONSIBLE PARTY INFORMATION (ANY PATIENT UNDER 18 YEARS OLD MUST HAVE A RESPONSIBLE PARTY)

- CUSTODIAL PARENT
- GUARDIAN (PROOF OF LEGAL STATUS REQUIRED FOR TREATMENT AT CHC)

LAST NAME **FIRST NAME** **MIDDLE INITIAL** **CHOSEN NAME (IF ANY)**

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

DATE OF BIRTH **PHONE NUMBER**



- RIVERSIDE • SAFE HARBOR • PEARL STREET • SCHOOL-BASED DENTAL CENTER •
- CHAMPLAIN ISLANDS • SOUTH END • GOOD HEALTH • WINOOSKI • ESSEX •

Consent for Treatment and Consent to Release Health Information

I. Consent for 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 (CHC). Treatment may include health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

II. Consent to release health information:

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, psychiatry and other treatment and health records ("health information") by CHC for the following purposes:

A. Use of health information by or for CHC for treatment, payment, and health care operations:

- Providing treatment by CHC staff.
- Conducting health care operations, including financial or quality assurance audits and/ or training.
- Bill your insurance company directly
- Payment for services provided by CHC. CHC is authorized to obtain payment for health care services and can provide health records to insurance companies, workers compensation insurers or other agencies that pay for health services, or other updated insurance information on file with CHC.

B. Disclosure of health information to persons or organizations outside of CHC for treatment purposes:

- CHC is authorized to provide all health information to other health providers or agencies who participate in your care. This includes past medical records from outside organizations. (An Individual release of information must be submitted for all family, friends, or other persons that you wish to access your Medical Record information.)

III. Assignment of Benefits

I authorize CHC to bill and receive payment directly from Medicaid /Medicare or any other insurance carrier for services provided to me.

I hereby assign to CHC all payments from Medicaid, Medicare, or any health insurance policy for health care, rendered to me by CHC.

I understand I am responsible for any unpaid balances incurred because of my care at CHC.

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

A copy of the CHC payment expectations is available at your request.

IV. Termination and restrictions of this consent:

- A. I understand that I have the right to cancel this consent at any time in writing, cancelling this consent will not affect any actions taken by CHC in reliance of this consent before it was cancelled. If not previously cancelled, this consent will end on the following date: _____ . If none is indicated, this consent will end three years after the last date of services to me.
- B. I understand that I may request restrictions on the use or disclosure of my health information for the purposes described in this consent and that CHC may or may not agree to the request. 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 you (or the named patient) without this signed consent.
- C. I have read this Consent for Treatment & Consent to Release of Health Information, and I understand and knowingly consent to its content.

I confirm that language access services were provided to me before I signed this Consent for Treatment & Consent to Release of Health Information form.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand CHC will use my protected health information in accordance with privacy law.

REQUIRED

Name of Patient: _____ Date of Birth _____
 Patient Signature: _____ Date: _____
 Parent/Guardian: _____
 Parent/Guardian Signature: _____ Date: _____

Medical/Dental History Form

Child's Name: _____ Date of birth: _____

School Child Attends: _____ Today's date: _____

Medical History

Please check any of the following that apply to your child:

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Handicap/Disability |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Autism Spectrum |
| <input type="checkbox"/> Other (please describe): _____ | | |

Other Health Information

Please check any of the following that apply to your child:

- My child smokes tobacco products
 - If yes, how much? _____
 - Are they interested in quitting? _____
- My child uses recreational drugs
- My child consumes alcohol
- My child is pregnant or possibly pregnant
- My child has sores in their mouth that are concerning
- My child has had trouble with previous dental work
- My child has been told they need antibiotics prior to past dental work
- My child has safety concerns at home or with friends
- Are there other dental or health concerns you would like to discuss today?
 - If yes, please describe:

Is your child allergic to or had a bad reaction to any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Codeine or other narcotics |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Penicillin or other antibiotics |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sedatives or sleeping pills |
| <input type="checkbox"/> Other (please describe): _____ | <input type="checkbox"/> Iodine |

Please list all the medications your student is taking (please include prescription and non-prescription drugs): _____

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 health care provider's office of any changes in my child's medical history.

Parent/Guardian Signature: _____ Date: _____

Signature of person completing form if not parent/guardian: _____

Contact Phone: _____

Consent to the Provision of Services

I authorize CHC – School-Based Dental Center to:

- Schedule and treat my child for preventative and restorative dental needs
- Only schedule and treat my child for dental needs when I have given permission (verbal or written)
- Only schedule and treat my child for dental needs when I am present (except in the care of a medical, dental, or mental health emergency)

Emergency Contact/Changes in Health Status or Custody

I further agree that I will promptly inform CHC staff in writing of:

- Any change in my child's physical or dental health and
- 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 CHC – School-Based Dental Center

The State of Vermont has contracted with Special Services Transportation Agency (SSTA) to provide transportation services for Medicaid eligible students to and from Burlington's schools and the CHC Dental Centers.

If my child needs transportation as indicated below, **I consent to having CHC schedule SSTA transportation take my child to and from their school for dental services, at no cost to me.** CHC may disclose information about my children's need for transportation and payment purposes.

Please note 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 via SSTA.
- Is at least 16 years of age and 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 is an acknowledgment that I have reviewed this form, understand the information and consent to all the actions described above. My signature also attests to the accuracy of the information provided on this form.

Parent/Guardian Signature: _____ Date: _____

Signature of person completing form if not parent/guardian: _____

Contact Phone: _____



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 _____