Community Health Centers

TAARIIKHDA DUWAANKA/GELINTA:
XARFAHA URUURISKA MAGACA SHAQAALAHA:

FOOMKA DUWAAN GELINTA BUKAANKA

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

Xarun ahaan Caafimaad oo U Qalanka oo Federal, CHC waxay dawladu uga baahan tahay inay uruuriso oo macluumaadka soo socda. **Fadlan oggow in dhamaan jawaabuhu yihiin sir.**

MACLUUMAADKA BUKAANKA (FADLAN KUWAXA BUUXI FOOMKA OO DHAN QALIN MADAW AMA BULUUG AH OO KALIYA)

MAGACA DANBE	MAGACA KOWAAD	MAGACA AABAHA	MAGACA RUUXU DOORTO (HADII UU JIRO)

CINWAANKA JIDKA	MAGAALADA	GOBOLKA	BOOSTA

CINWAANKA BOOSTA (HADII UU KA DUWAN YAHAY KA RUUXU DEGAN YAHAY)

LAMBARKA SOOSHAAL SEKUURITIGA	TAARIIKHDA DHALASHADA	WAXA LOOGU YEEDHO RUUXA

TALEEFANKA GACANTA	TALEEFANKA SHAQADA	TALEEFANKA GURIGA

CINWAANKA IIMEELKA

QAABKA XIDHIIDHKA LA DOORBIDAYO
☐TALEEFAN ☐ FARIIN QORAAL AH
☐IIMEEL ☑ DAAQADA BUKAANKA

JINSIGA SHARCIGA AH
☐DHEDIG
☐LAB

JINSIGA WAKHTIGAN
☐DHEDIG
☐LAB

AQOONSIGA JINSIGA
☐DHEDIG
☐LAB
☐NAAG JINSIGA BEDESHAY (GABADH NIN LAGA DHEIGAY)
☐NIN JINSIGA BEDELEY (NIN NAAG ISKA DHIGAY)
☐KHANIIS
☐WAXKALE
☐MA DOONAYO IN AAN SHEEGO

RABITAANKA JINSIGA
☐JINSI CAADI AH
☐KHANIISAD, KHANIIS, ama KHANIIS
☐LABEEB
☐WAX KALE
☐MAGARANAYO
☐MA DOONAYO IN AAN SHEEGO

LUUQADA KOWAAD

MIYAAD U BAAHAN TAHAY ADEEGA TURJUBAADA?
☐HAA ☐MAYA

XAALADA GUURKA
☐KALI ☐KALA MAQAN
☐GUURSADAY ☐CARMAL
☐KALA TAGAY ☐ ISKA WADA NOOL

MA WAXA AAD TAHAY CIIDAN MARAYKAN OO HAWL GABAY?
☐HAA
☐MAYA

MA WAXA AAD TAHAY SHAQAALE BEEREED?
☐MAYA
☐SOO GELEYTI
☐XILIYEED

XAALADA GURYAYNTA
MA BILAA GURI AYAAD TAHAY? ☐HAA ☐MAYA
HADII AAD BILAA GURI TAHAY, MIYAAD: ☐LA TAHAY DULSAAR (LA NOOSHAHAY RUUX KALE) ☐HOY ☐JIDKA ☐KALA GUUR ☐LAMA GARANAYO

QOOMIYADA (DOORO DHAMAAN INTA AY KHUSAYSO)

AASIYAAN	DHALAD MARAYKAN AMA JASIIRADA BAASIFIGA	MADAW AMA MARAYKAN MADAW	HINDIDA MARAYKANKA AMA DHALAD ALASKA	CADAAN	MA DOONAYO IN AAN SHEEGO
☐JAYNIIS	☐DHALAD HAWAII	☐MADAW AMA MARAYKAN MADAW	☐HINDIDA MARAYKANKA AMA DHALAD ALASKA	☐CADAAN	☐MA DOONAYO IN AAN SHEEGO
☐VIETNAMESE	☐JASIIRADAHA KALE EE BAASIFIGA				
☐HINDIDA AASIYA	☐GUAMANIAN AMA CHAMORRO				
☐KOREAN	☐SAMOAN				
☐FILIPINO					
☐ JAPANESE					
☐ AASIYAAN KALE					

QOOMIYAD

HISBAANIG, LAATIINO, AMA ISKAANISH KASOO JEEDA	AAN AHAYN ISBAANIG, LATALINO/A, KASOO JEEDA ISBAANIK	MA DOONAYO IN AAN SHEEGO
☐MEKSIKAAN ☐MEKSIKAANKA MARAYKANKA ☐CHICANO	☐AAN AHAYN HISBAANIG, LAATIINO, AMA ISKAANISH KASOO JEEDA	☐MA DOONAYO IN AAN SHEEGO
☐PUERTO RICAN		
☐KUUBAAN		
☐HISBAANIG, LAATIINO, AMA ISKAANISH KASOO JEEDA		
☐HISBAANIG, LAATIINO, IYO ISKAANISH KASOO JEEDA KALE		

Community Health Centers

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
☐PHONE ☐ TEXT
☐EMAIL ☐ PATIENT PORTAL

LEGAL SEX
☐FEMALE
☐MALE

CURRENT GENDER
☐FEMALE
☐MALE

GENDER IDENTITY
☐FEMALE
☐MALE
☐TRANSGENDER MALE (FEMALE-TO-MALE)
☐TRANSGENDER FEMALE (MALE-TO-FEMALE)
☐GENDERQUEER
☐OTHER
☐CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐STRAIGHT OR HETEROSEXUAL
☐LESBIAN, GAY, OR HOMOSEXUAL
☐BISEXUAL
☐SOMETHING ELSE
☐DON'T KNOW
☐CHOOSE NOT TO DISCLOSE

PRIMARY LANGUAGE

DO YOU NEED INTERPRETER SERVICES?
☐YES ☐NO

MARITAL STATUS
☐SINGLE ☐SEPERATED
☐MARRIED ☐WIDOWED
☐DIVORCED ☐ CIVIL UNION

ARE YOU A U.S. VETERAN?
☐YES
☐NO

ARE YOU AN AGRICULTURAL WORKER?
☐NO
☐MIGRANT
☐SEASONAL

HOUSING STATUS
ARE YOU HOMELESS? ☐YES ☐NO
IF HOMELESS, ARE YOU: ☐DOUBLING UP (LIVING WITH OTHERS) ☐SHELTER ☐STREET ☐TRANSITIONAL ☐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
☐CHINESE	☐NATIVE HAWAIIAN	☐BLACK OR AFRICAN AMERICAN	☐AMERICAN INDIAN OR ALASKA NATIVE	☐WHITE	☐CHOOSE NOT TO DISCLOSE
☐VIETNAMESE	☐OTHER PACIFIC ISLANDER				
☐ASIAN INDIAN	☐GUAMANIAN OR CHAMORRO				
☐KOREAN	☐SAMOAN				
☐FILIPINO					
☐ JAPANESE					
☐ OTHER ASIAN					

ETHNICITY

HISPANIC, LATINO/A, OR SPANISH ORIGIN	NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN	CHOOSE NOT TO DISCLOSE
☐MEXICAN ☐MEXICAN AMERICAN ☐CHICANO	☐NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN	☐CHOOSE NOT TO DISCLOSE
☐PUERTO RICAN		
☐CUBAN		
☐ HISPANIC, LATINO/A, OR SPANISH ORIGIN		
☐ANOTHER HISPANIC, LATINO/A, AND SPANISH ORIGIN		

MAGACA BUKAANKA: **TAARIIKHDA DHALASHADA:**

MACLUUMAADKA DHAQAALE FADLAN GOOBAAB CABIRKA QOYSKA SAXDA AH IYO HEERKA DAKHLIGA QOYSKU INTA UU U DHAXEEYO SHAXDA HOOSE. *DHAMAAN JAWAABUHU WAA SIR*

TILMAAMAHA SABOOLNIMADA FEDERALKA 2024				
CABIRKA QOYSKA	**0-100% HEERKA SABOOLNIMADA FEDERALKA**	**101-150% HEERKA SABOOLNIMADA FEDERALKA**	**151-200% HEERKA SABOOLNIMADA FEDERALKA**	**WAX KA SAREEYA 200% HEERKA SABOOLNIMADA FEDERALKA**
	DAKHLIGA QOYSKA SANADKII WAXA UU U DHAXEEYAA IYADA OO LAGA DUULAYO CABIRKA QOYSKA			
1	$0 ILAA $15,060	$15,061 ILAA $22,590	$22,591 ILAA $30,120	$30,121 & WIXII KA SAREEYA
2	$0 ILAA $20,440	$20,441 ILAA $30.6060	$30,661 ILAA $40,880	$40,881 & WIXII KA SAREEYA
3	$0 ILAA $25,820	$25,821 ILAA $38,730	$38,731 ILAA $51,640	$51,641 & WIXII KA SAREEYA
4	$0 ILAA $31,200	$31,201 ILAA $46,800	$46,801 ILAA $62,400	$62,401 & WIXII KA SAREEYA
5	$0 ILAA $36,580	$36,581 ILAA $54,870	$54,871 ILAA $73,160	$73,161 & WIXII KA SAREEYA
6	$0 ILAA $41,960	$41,961 ILAA $62,940	$62,941 ILAA $83,920	$83,921 & WIXII KA SAREEYA
7	$0 ILAA $47,340	$47,341 ILAA $71,010	$71,011 ILAA $94,680	$94,681 & WIXII KA SAREEYA
8	$0 ILAA $52,720	$52,721 ILAA $79,080	$79,081 ILAA $105,440	$105,441 & WIXII KA SAREEYA
9	$0 ILAA $58,100	$58,101 ILAA $87,150	$87,151 ILAA $116,200	$116,201 & WIXII KA SAREEYA
10	$0 ILAA $63,480	$63,481 ILAA $95,220	$95,221 ILAA $126,960	$126,961 & WIXII KA SAREEYA
*****	**KU DAR $5,380 RUUXII KASTA OO DHEERAAD AH EE XUBIN QOYSKA AH.*	**KU DAR $8,070 RUUXII KASTA OO DHEERAAD AH EE XUBIN QOYSKA AH.*	**KU DAR $10,760 RUUXII KASTA OO DHEERAAD AH EE XUBIN QOYSKA AH.*	

MACLUUMAADKA CAYMISKA ILKAHA

☐ Waxa aan leeyahay caymiska ilkaha wakhtigan.

☐ Ma haysto wakhti xaadirkan caymiska ilkaha.

☐ Ma doonaysaa inaad dalbato miisaanka heerka.

MAGACA SHIRKADA CAYMISKA ILKAHA:
LAMBARKA/AQOONSIGA CAYMISKA
MAGACA RUUXA KU QORAN CAYMISKA:

MACLUUMAADKA CAYMISKA ILKAHA EE LABAAD:
MAGACA SHIRKADA CAYMISKA ILKAHA:
LAMBARKA/AQOONSIGA CAYMISKA
MAGACA RUUXA KU QORAN CAYMISKA:

MACLUUMAADKA CAYMISKA CAAFIMAADKA

☐ Waxa aan leeyahay caymiska caafimaad wakhtigan.

☐ Ma haysto wakhti xaadirkan caymiska caafimaad.

☐ Ma doonaysaa inaad dalbato miisaanka heerka.

MAGACA SHIRKADA CAYMISKA CAAFIMAADKA:
LAMBARKA/AQOONSIGA CAYMISKA
MAGACA RUUXA KU QORAN CAYMISKA:

MACLUUMAADKA CAYMISKA CAAFIMAADKA EE LABAAD:
MAGACA SHIRKADA CAYMISKA CAAFIMAADKA:
LAMBARKA/AQOONSIGA CAYMISKA
MAGACA RUUXA KU QORAN CAYMISKA:

FARMASIGA AAD DOOR BIDO

MAGACA FARMASIGA **GOOBTA FARMASIGA**

MACLUUMAADKA XIDHIIDHKA XAALADA DEGDEGA AH

MAGACA **XIDHIIDHKA** **TALEEFAN LAMBARKA**

MACLUUMAADKA CIDA MASUULKA AH (WIXII BUKAAN AH EE KA YAR 18 JIR WAA INUU LEEYAHAY CID KA MASUUL AH)

☐ **WAALIDKA GACANTA KU HAYA**

☐ **KORIYAHA** (CADAYNTA XAALADA SHARCIGA AH EE U BAAHAN DAAWAYNTA CHC)

MAGACA DANBE **MAGACA KOWAAD** **MAGACA AABAHA** **MAGACA RUUXU DOORTO (HADII UU JIRO)**

CINWAANKA JIDKA **MAGAALADA** **GOBOLKA** **BOOSTA**

TAARIIKHDA DHALASHADA **LAMBARKA TALEEFANKA**

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
*****	**ADD $5,380 PER EACH ADDITIONAL FAMILY MEMBER.*	**ADD $8,070 PER EACH ADDITIONAL FAMILY MEMBER.*	**ADD $10,760 PER EACH ADDITIONAL FAMILY MEMBER*	

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**

Community Health Centers

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

Ogolaanshaha Daawaynta iyo Ogolaanshaha Bixinta Macluumaadka 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 (CHC). Daawaynta waxaa kamid ah shaybaadhka, baadhitaanka iyo daawaynta caafimaad, daryeelka ilkaha; adeegyada bulshada; caafimaadka iyo/ama shaybaadhka caafimaadka maskaxda ama khamrida, qiimaynta, xanuunka iyo daawaynta, adeegyada iyo adeegyada dhakhtarka cilmi nafsiga.

II. Ogolaanshaha bixinta macluumaadka 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, dhakhtarka cilmi nafsiga iyo daawaynaha kale iyo caafimaadka ("macluumaadka cafimaadka") ee CHC wixii ah ujeedada soo socota:

A. Isticmaalka macluumaadka caafimaadka ee ama loogu talo geley daawaynta, bixinta iyo shaqada daryeelka caafimaad ee CHC:

- Bixinta daawaynta shaqaalaha CHC:
- Qabashada shaqooyinka daryeelka caafimaad, oo waxaa ku jiwa, hantidhawrka dhaqaale ama tayada caymiska iyo/ama tobobarka.
- Toos ugu dalicida shirkadaada caymiska ah lacagta
- Lacagta adeegyada ay bixisay CHC. CHC waxaa loo ogol yahay inay siiso adeegyada daryeelka caafimaadka iyo inay siiso duwaanada caafimaadka la bixiyay shirkadaha caymiska, caymiska gunada shaqaalaha ama hay'adaha kale ee bixiya adeegyada caafimaadka, iyo macluumaadka caymiska ee ugu danbeeya ee kale ee ku jira faylka CHC hayso.

B. Bixinta macluumaadka caafimaadka ee qoyska ama hay'adaha ka baxsan wixii ah ujeedo daawaynta CHC:

- CHC waxay sisaa dhaaman macluumaadka caafimaadka bixiyayaasha caafimaadka ee kale ama hay'adaha ku jira daryeelkaaga. Tan waxaa kamid ah duwaanada caafimaadka ee hore ee hay'adaha banaanka ah. (Macluumaadka si shakhsi ahaaneed ay tahay in loo bixiyo waa in loo gudbiyo dhamaan qoyska, asxaabta, ama shakhsiyadka kale ee doonaya inay galaan macluumaadkaaga Duwaanka Caafimaadka.)

Community Health Centers

• RIVERSIDE • SAFE HARBOR • PEARL STREET • SCHOOL-BASED DENTAL CENTER •
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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. Ku Qorida Gunooyinka

Waxa aan u ogolaaday CHC inay ku dalacdo oo ay si toos ah uga hesho lacagta Medicaid/Medicare ama wixii caymis ah ee adeegyada la i siiyay.

Waxa aan halkan ku saxeexayaa in CHC ay dhamaan lacagta Medicaid, Medicare, ama wixii kale ee caymiska caafimaadka ah ee daryeelka caafimaadka, ee ay i siisay CHC.

Waxa aan fahansanahay in aan ka masuul ahayn 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**.**

Nuqulka filashooyinka lacagta CHC waxaa la heli karaa marka la dalbado.

IV. Joojinta iyo xadidaada ogolaanshahan:

A. Wax aaan fahamsanahay in aan xaq u leeyahay in aan joojiyo ogolaanashahan wakhtiga kasta iyada oo qoraal ah, joojinta ogolaanshahan ma saamayn doono wixii talaabooyin ah ee ay qaaday CHC iyada oo ka duulaysa ogolaanshahan kahor inta aan la joojin. Hadii aan hore u joojiyay, ogolaanshahan waxa uu ku eeg yahay taariikhda soo socda: _____. Hadii aan midna la sheegin, ogolaanshahan waxa uu ku eeg yahay sadex sano kadib taariikhda ugu danbaysa ee adeegyada la i siiyo.

B. 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. Waxa aan fahansanahay in marka laga tago wixii xadidaado ah ee isticmaal ama bixin macluumaadka caafimaad ee lagu heshiiyay, CHC inayna siinin adeegyada adiga (ama bukaanka lagu sheegey magiciisa kor) iyada oo aan la heynin ogolaanshe saxeexan.

C. Waxa aan akhriyay Ogolaanshaha Daawaynta & Ogolaanshaha Bixinta Macluumaadka Caafimaad oo aan fahmay oo aniga oo og ayaan ogolaadan ogolaanshaheeda.

Waxaan xaqiijinayaa in la i siiyay adeegyada luuqada kahor inta aanan saxeexin foomka Ogolaanshahan Daawaynta & Ogolaanshaha Bixinta Macluumaadka Caafimaadka.

Waxaan halkan ku qirayaa in la i siiyay koobiga Ogeysiiska Habdhaqanka Qarsoonnimada waxaanan fahansanahay in CHC ay u isticmaali doonto macluumaadkayga caafimaad si waafaqsan sharciga sirta.

Magaca Bukaanka: _____ Taariikhda Dhalashada: _____
Saxeexa Bukaanka: _____ Taariikhda: _____
Waalidka/Koriyaha: _____
Saxeexa Waalidka/Koriyaha: _____ Taariikhda: _____

LOO BAAHAN YAHAY

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:_____

Xarfaha Lasoo Gaabiyay ee Dhakhtarka Ilkaha:

Community Health Centers
SCHOOL-BASED DENTAL CENTER

Foomka Taariikhda Caafimaadka/Daryeelka Ilkaha

Magaca Ilmaha: _____ Taariikhda Dhalashada: _____

Dugsiga Ilmuhu Dhigto: _____ Taariikhda Maanta: _____

Taariikhda Caafimaadka

Fadlan sax wixii khuseeya kuwa soo scoda ilmahaaga:

☐ Xiiq
☐ Kaansar
☐ Joonis
☐ HIV/Aydhis
☐ Hemophilia
☐ Macaan
☐ Xasaasiyado
☐ Waxne Xanuun
☐ Suuxdin
☐ Qaaxo
☐ Dhiigid Aan Caadi Ahayn
☐ Mushkilad Sanboor ah
☐ Dhiig yaraan
☐ Ximada Rheumatic
☐ Laxaad La'aan
☐ Heart Murmur
☐ ADHD
☐ Autism Spectrum
☐Waxkale(fadlan sharax): _____

Macluumaadka Caafimaad ee Kale

Fadlan sax wixii khuseeya kuwa soo scoda ilmahaaga:

☐ Ilmahaygu waxa uu cabaa sigaarka
- Hadii haa tahay, imisa? _____
- Ma doonayaa inuu joojiyo? _____

☐ Ilmahaygu waxa uu isticmaalaa mukhaadaraadka
☐ Ilmahaygu waxa uu cabaa khamrida
☐ Ilmahaygu uur ayuu leeyahay ama waa macquul inuu uur leeyahay
☐ Ilmahayga waxa uu ka khuuriyaa afkiisa oo waa shay aan ka warwaro
☐ Ilmahaygu waxa uu hore u qabay mushkilad dhanka shaqada daryeelka ilmaha ah
☐ Ilmahaygy waxa loo sheegey inuu u baahan yahay antibootig kahor inta aan loo bilaabin shaqada daryeelka ilkaha
☐ Ilmahaygu waxa uu qabaa walaac amaan marka uu joogo guriga ama uu asxaabtii la joogo
☐ Ma jiraan wax walaacyo kale oo daryeelka ilkaha ama caafimaadka ah oo aad doonayso inaad maanta ka hadasho?
- Hadii ay haa tahay, fadlan sharax: _____

Miyaa ilmahaagu xasaasiyad ka qaadaa ama jawaab celin xun ka leeyahay waxyaabaha soo socda:

☐ Suuxdina aaga
☐ Cinjirka
☐ Asbiriin
☐ Waxkale(fadlan sharax):
☐ Codeine ama narcotics kale
☐ Banasiliin ama antobootiga kale
☐ Kiniinka suuxdinta ama hurdada
☐ Ayodhiinta

_____

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

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Dentist Initials:

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:

☐ Asthma	☐ Allergies	☐ Anemia
☐ Cancer	☐ Congenital Heart Defect	☐ Rheumatic Fever
☐ Hepatitis	☐ Seizures/Epilepsy	☐ Handicap/Disability
☐ HIV/AIDS	☐ Tuberculosis	☐ Heart Murmur
☐ Hemophilia	☐ Abnormal Bleeding	☐ ADHD
☐ Diabetes	☐ Sinus Trouble	☐ Autism Spectrum

☐ 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:

☐ Local anesthetics	☐ Codeine or other narcotics
☐ Latex	☐ Penicillin or other antibiotics
☐ Aspirin	☐ Sedatives or sleeping pills
☐ Other (please describe):	☐ Iodine

_____

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

_____

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_____

_____

Fadlan saxeex hoos si aad u xaqiijiso daryeelka ilkaha/caafimaad oo haboon inuu helo ilmahaagu. Ilaa inta aan ogahahay, 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: _____

Saxeexa qofka buuxinaya foomkan hadii aanu ahayn waalid/koriye:

_____

Taleefanka Xidhiidhka: _____

Ogolaanshaha Bixinta Adeegyada

Waxaan u ogolaaday CHC - Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan inay:

☐ U samayso balan oo ay u fidiso daawaynta ilmahayga kahortaga iyo soo celinta daryeelka ilmaha ee loo baahan yahay

☐ Kaliya u qalbataan balan oo ay ka daweeyaan baahiyaha daryeelka ilmaha marka aan siiyo ogolaanshe (afka ama qoraal ah)

☐ Kaliya u qabtaan balanta oo ka daweeyaan ilmahayga wixii baahi daryeelka ilkaha ee uu qabo marka aan joogo (marka laga tago daryeelka caafimaadka, ilmaha ama caafimaadka maskaxda ee xaalada 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 CHC iyada oo qoraal ah:

- Wixii isbadal ah ee caafimaadka jidhka ama ilkaha ee ilmahayga ku yimaada iyo
- 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 CHC - Xarunta Daryeelka Ilmaha Dugsiga Kusalaysan

Gobolka Vermont waxa uu qandaraas ku siiyay Hay'ada Gaadiidka Adeegyada Gaarka ah (SSTA) inay siiso adeegyada gaadiidka ardayda u qalantan Medicaid ee ay ku imanayaan iyo kaga tagayaan dugsiyada Burlington iyo Xarunta Daryeelka Ilmaha ee CHC.

☐ 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 dugsigooda ee adeegyada ilkaha, iyada oo bilaash ah.** CHC waxay u bixin karaan macluumaadka caruurtayda wixii baahida gaadiidka iyo wixii ujeedo lacageed ah.

Fadlan oggow in SSTA ay ka dalban karto gudid lacageed Medicaid wixii adeegyada gaadiidka ah.

Hadii ilmahayga la arko dhamaadka maalinta dugsiga, ilmahayga:
☐ Waa in lasoo qaado oo guriga lagu keeno SSTA.
☐ Waxaa weeye ugu yaraan 16 jir oo 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. Saxeexaygu 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.

Saxeexa Waalidka/Koriyaha: _____ Taariikhda: _____

Saxeexa qofka buuxinaya foomkan hadii aanu ahayn waalid/koriye:
_____

Taleefanka Xidhiidhka: _____

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: _____

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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_____