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

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

SEX AT BIRTH
☐ 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 ☐ SEPARATED
☐ 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		

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

HOUSEHOLD ANNUAL INCOME RANGE BASED ON FAMILY SIZE				
1	$0 to $15,960	$15,961 to $23,940	$23,941 to $31,920	$31,921 & over
2	$0 to $21,640	$21,641 to $32,460	$32,461 to $43,280	$43,281 & over
3	$0 to $27,320	$27,321 to $40,980	$40,981 to $54,640	$54,641 & over
4	$0 to $33,000	$33,001 to $49,500	$49,501 to $66,000	$66,001 & over
5	$0 to $38,680	$38,681 to $58,020	$58,021 to $77,360	$77,361 & over
6	$0 to $44,360	$44,361 to $66,540	$66,541 to $88,720	$88,721 & over
7	$0 to $50,040	$50,041 to $75,060	$75,061 to $100,080	$100,081 & over
8	$0 to $55,720	$55,721 to $83,580	$83,581 to $111,440	$111,441 & over
9	$0 to $61,400	$61,401 to $92,100	$92,101 to $122,800	$122,801 & over
10	$0 to $67,080	$67,081 to $100,620	$100,621 to $134,160	$134,161 & over
*	**ADD $5,680 PER EACH ADDITIONAL FAMILY MEMBER.*	**ADD $8,520 PER EACH ADDITIONAL FAMILY MEMBER.*	**ADD $11,360 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:
POLICY HOLDER ADDRESS:
POLICY HOLDER PHONE NUMBER:
POLICY HOLDER DATE OF BIRTH:

SECONDARY DENTAL INSURANCE INFORMATION:
DENTAL INSURANCE NAME:
POLICY/ID NUMBER:
POLICY HOLDER NAME:
POLICY HOLDER ADDRESS:
POLICY HOLDER PHONE NUMBER:
POLICY HOLDER DATE OF BIRTH:

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:
POLICY HOLDER ADDRESS:
POLICY HOLDER PHONE NUMBER:
POLICY HOLDER DATE OF BIRTH:

SECONDARY MEDICAL INSURANCE INFORMATION:
MEDICAL INSURANCE NAME:
POLICY/ID NUMBER:
POLICY HOLDER NAME:
POLICY HOLDER ADDRESS:
POLICY HOLDER PHONE NUMBER:
POLICY HOLDER DATE OF BIRTH:

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 •

Consent for Treatment

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. Assignment of Benefits

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

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

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

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

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

III. 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 have read this Consent for Treatment, and I understand and knowingly consent to its content.

IV. SMS Consent Checkbox

☐ I consent to receive text messages from Community Health Centers of Burlington. These may include appointment reminders, scheduling updates, and other messages related to my care. Message frequency varies. Message and data rates may apply. Consent is not a condition of receiving care or services.

REQUIRED

Patient Name:_____ Date of Birth:_____

Patient Signature:_____ Date:_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ Date:_____

Revised 6/30/26

Community Health Centers
SCHOOL-BASED DENTAL CENTER

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):_____

_____

Revised November 2023

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: _____

Revised November 2023

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_____