School-Based Dental Center
Medical/Dental History Form

Pre-K thru 8th Grade

44 Main Street, Richford, VT 05476 ■Tel: 255-5520 ■ Fax: 255-5529

1. Northern Tier Center for Health (NOTCH) offers portable preventive clinical care at multiple schools across the FNESU school district.
2. All students who attend FNESU schools are eligible and welcome. If you are uninsured, NOTCH will provide Patient Support Services to assist you in applying for programs and/or our Sliding-Fee Scale Program.
3. Please complete this form and return it to your school nurse. Please contact your school nurse or NOTCH's Richford Dental Clinic at 255-5520 if you need help completing this form.

Once your child is enrolled, the school and NOTCH will take care of everything else for you. Dental care for your child has never been so easy!

Please fill out this form **completely** and sign each page requiring a signature. **Each child** needs a separate registration form. If another form is needed, contact your child's school health department or NOTCH Richford Dental Clinic at 802-255-5520

School Name: _____

Child's Information

Today's Date: _____

Child's Name: _____ DOB: _____ SSN: _____

Child's Preferred Name: _____ Language: ☐ English ☐ Other: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

Primary Care Provider: _____ Phone Number: _____ Last Visit: _____

Primary Dental Provider: _____ Phone Number: _____ Last Visit: _____

Primary Pharmacy: _____

As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

Race	**Ethnicity/ Ethnic Origin**	**Gender**	**Sexual Orientation**	**Legal Sex**
☐ African American	☐ Hispanic	☐ Male	☐ Lesbian or Gay	☐ Male
☐ Asian-American	☐ Non-Hispanic	☐ Female	☐ Straight/Heterosexual	☐ Female
☐ Caucasian/White		☐ Transgender Male	☐ Bisexual	
☐ Native American		☐ Transgender Female	☐ Something Else	
☐ Pacific Islander		☐ Other	☐ Don't Know	
☐ Multi-Racial		☐ Do Not Wish to Report	☐ Do Not Wish to Report	

Parent/Guardian Information

Name of Person Legally Responsible for Child: _____ Relationship: _____

Primary Contact #: _____ Email: _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

Alternate Contact: _____ Relationship: _____

Child's Name: _____ DOB: _____

Insurance Information

Dental Insurance Carrier Name: _____ ID #: _____

Name of Insurance Subscriber: _____ DOB: _____ SSN: _____

As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

Family Size	0-100%			101-150%			151%-200%			Over 200%	
	2024 Household 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	$30,660	$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

Your Child's overall health, as well as any medications that your child takes could have an impact on your child's medical/dental care. Please answer each of the following questions completely

1. Have you ever been told your child needs antibiotics prior to going to the Dentist? ☐ Yes ☐ No
2. Has your child had any trouble with previous visit to the Dentist? ☐ Yes ☐ No
   If yes, please explain: _____

Medical History

Does your child have any of the following diseases or problems? If **yes,** please check the corresponding box:

YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Convulsions/Epilepsy
☐	☐	Cancer	☐	☐	Tuberculosis
☐	☐	Hepatitis	☐	☐	Abnormal Bleeding
☐	☐	HIV/AIDS	☐	☐	Sinus Trouble
☐	☐	Hemophilia	☐	☐	Anemia
☐	☐	Diabetes	☐	☐	Rheumatic Fever
☐	☐	Allergies	☐	☐	Handicap/Disability
☐	☐	Congenital Heart Defect	☐	☐	Heart Murmur

Does your child grind teeth, clench jaw, or chew on hard objects? ☐ Yes ☐ No

Child's Name: _____ DOB: _____

Any other medical problems not listed (Please explain): _____

_____

List any medications your child is taking (please include prescription and non-prescription medications)

_____ _____

_____ _____

Is your Child's Water Fluoridated? ☐ Yes ☐ No

Does your child take fluoride supplements? ☐ Yes ☐ No

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

YES	NO		YES	NO	
☐	☐	Local anesthetics (Novocain)	☐	☐	Penicillin or other antibiotics
☐	☐	Latex	☐	☐	Sedatives, barbiturates, or sleeping pills
☐	☐	Aspirin	☐	☐	Iodine
☐	☐	Codeine or other narcotics	☐	☐	Other:

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.

Consent to the Provision of Services:

I authorize NOTCH to see my child at their school (please select):

☐ Whenever my child needs dental care

☐ Only when I have given specific written permission (except in the case of 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 Clinic 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.

Attestation and Signature:

I (parent/guardian name) _____ have read the above material and understand its meaning. My signature below is acknowledgement that I have reviewed this form, understand the information and consent to all the actions described above. In addition, my signature also attests to the accuracy of the information provided on this form.

_____

Parent/guardian Name

_____ _____

Parent/guardian Signature Date

Child's Name: _____ DOB: _____

Consent to Treatment and Consent to Release Health Information for Treatment, Payment, and Health Care Operations

I. Consent to Treatment:

I hereby give my consent for treatment for my child _____ (of whom I am the parent or legal guardian who has the right to consent to treatment for this child) to Northern Tier Center for Health (NOTCH). Treatment may include examinations, dental cleanings, x-rays, fluoride application, sealants, and Silver Diamine Fluoride application (see separate consent). I further understand this Consent covers only dental services provided at my child's school, Richford/Swanton Dental Clinic. I understand NOTCH will protect the privacy of my child's health and educational records to the extent required by federal and state law

II. Consent to Release of Health Information, including Health/Treatment Records for Treatment, Payment and Health Care Operations

I consent to the use within NOTCH and the disclosure to persons or organizations outside of NOTCH 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 NOTCH for the following purposes:

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

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

B. Disclosure of Health Information to Persons Outside NOTCH for Treatment Purposes and for Payment

- Providing all necessary Health Information as determined by NOTCH, if referred for further treatment.
- Providing Health Information to other health providers or agencies who may be involved in my child's care.
- Obtaining payment for health care bills, including sending such Health Information as is needed to secure payment for NOTCH services to the insurance company, or agency that pays for my health services, as identified in my NOTCH Registration form or other updated insurance information on file with NOTCH.
- School-Based Dental Program may share treatment and health information with FNESU school health personnel and Northern Tier Center for Health (NOTCH).

III. Other Matters

I understand that I have the right to revoke this Consent at any time, by revoking this Consent it will not affect any actions which were taken by NOTCH prior to the time of revoking.

I understand that I may request restrictions on use or disclosure of my Health Information for the purposes described in this Consent and that NOTCH 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, NOTCH will not be able to provide services to my child without this signed Consent.

_____

Parent/guardian Name

_____ _____

Signature of parent/guardian Date

Child's Name: _____ DOB: _____

I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of care at NOTCH.

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

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

Assignment of Benefits

- I hereby assign to NOTCH any and all payments to which my child is entitled under Medicaid for dental health services rendered to me by NOTCH as long as the charges for services by NOTCH do not exceed NOTCH's regular charges. I further authorize NOTCH to bill and receive payment directly from Medicaid for those services that NOTCH delivered and for which my child may be entitled to coverage. I also authorize NOTCH to give Medicaid any information necessary for billing purposes for services provided for such periods of time as received for dental health services.
- Patients at Northern Tier Center for Health (NOTCH) consent to disclosure of information for purposes of treatment, payment, and health care operations. Patient may consent to receipt or disclosures of health care information for other purposes as well.
- I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand how NOTCH may and may not use my protected health information in accordance with privacy law.
- I understand that Northern Tier Center for Health (NOTCH) 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.

_____

Parent/guardian Name

_____ _____

Signature of parent/guardian Date

Secretary of State
Office of Professional Regulation

DENTAL EXAMINERS
SDF Informed Consent Form

Patient Name: _____
Date of Birth: _____

Silver Diamine Fluoride (SDF), a liquid approved by the FDA for treatment of sensitive teeth, provides an effective means to temporarily slow active decay until dental treatment can be obtained.

The Procedure:

- Dry teeth.
- Apply SDF to cavities in very small amounts and allow it to dry for 1 minute.
- Do not eat or drink for one hour. After treatment, do not brush your teeth today.

Please let us know if you have one of the following allergies or pre-existing conditions as it may be a reason not to use SDF:

- Allergies to silver or other metals
- Painful mouth sores
- Any abnormal skin sensitivities.

Possible Side Effects:

- SDF will turn a cavity black. See pictures below.
- A metallic taste in the mouth, which will go away quickly.
- If SDF comes in contact with skin and/or gums, temporary staining will occur.
- If SDF is placed on a tooth that has a tooth colored filling, staining may occur.

Please note:

- The side effects listed above may not include all of the side effects reported by the drug's manufacturer. If you notice other effects not listed above, please contact us.
- Treatment of tooth decay with SDF may not prevent the need to place a regular filling in the affected tooth in the future to restore function and esthetics.
- SDF treatment should be repeated within the next six months if you have not yet received dental treatment.

I, _____, have read this form and understand the treatment. The treatment, including the risks and benefits, has been explained to me to my satisfaction and I have had the chance to ask questions. I understand that there is no promise that this treatment will be successful. I hereby give my consent to have a licensed dental hygienist perform this procedure.

Date: _____
Signature of Patient: _____
Signature of Patient's Parent, Guardian, or Legal Representative (if applicable):
_____

These teeth have been treated with SDF.