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 (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 ☐ Vietnamese ☐ Asian India ☐ Korean ☐ Filipino ☐ Japanese ☐ Other Asian	☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan	☐ Black or African American	☐ American Indian or Alaska Native	☐ White	☐ Choose not to Disclose

Child's Name: _____ DOB: _____

ETHNICITY		
HISPANIC, LATINO/A, OR SPANISH ORIGIN	NOT HISPANIC, LATINO/A OR SPANISH ORIGIN	CHOOSE NOT TO DISCLOSE
☐ Mexican ☐ American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Hispanic, Latino/A, or Spanish Origin ☐ Another Hispanic, Latino/A, and Spanish Origin	☐ Not Hispanic, Latino/a or Spanish origin	☐ Choose not to disclose

Parent/Guardian Information

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

Primary Contact #: _____ Email: _____

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

Alternate Contact: _____ Relationship: _____

Primary Contact #: _____ Email: _____

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

Insurance Information

Dental Insurance Carrier Name: _____ ID #: _____

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

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	0-100% Federal Poverty Level				101-150% Federal Poverty Level				151%-200% Federal Poverty Level				Over 200% Federal Poverty Level	
Family Size	**Household Income Range based on Family Size**													
1	$0	to	$15,650		$15,651	to	$23,475		$23,476	to	$31,300		$31,301	& over
2	$0	to	$21,150		$21,151	to	$31,725		$31,726	to	$42,300		$42,301	& over
3	$0	to	$26,650		$26,651	to	$39,975		$39,976	to	$53,300		$53,301	& over
4	$0	to	$31,320		$31,321	to	$48,225		$48,226	to	$64,300		$64,301	& over
5	$0	to	$36,700		$36,701	to	$56,475		$56,476	to	$75,300		$75,301	& over
6	$0	to	$42,080		$42,081	to	$64,725		$64,726	to	$86,300		$86,301	& over

**Add $5,500 per each additional over 6*

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: _____

Child's Name: _____ DOB: _____

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

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.

Child's Name: _____ DOB: _____

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 for the use and disclosure of health information for treatment payment and Health Care Operations

Patient Name: _____ **Date of Birth**: _____
Please Print Please Print

I. Consent for Treatment:

I hereby give my consent for treatment for myself, or the named patient (of who I am the parent or legal guardian of and has the legal right to consent to treatment for the named patient) to the Northern Tier Centers for Health (Notch). Treatment may include health screening, diagnosis, medical treatment, dental treatment, mental health, psychiatry services, and drug and alcohol screening, assessment, diagnosis, and treatment.

II. Consent to Release Health Information

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, Care Quality Interoperative (HIE), Surescripts/Pharmacy, drug and alcohol, mental health, psychiatry and other treatment and health records ("health information") by Notch for the following purposes:

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

- Providing treatment by Notch staff
- Conducting health care operations, including financial or quality assurance audits and / or training.
- Prescription ordering/refilling
- Bill your insurance company directly
- Payment for health care services and can provide health records to insurance companies, workers compensation / liability insurance or other agencies that pay for health services, or other updated insurance information on file with Notch.

B. Disclosure of health information to people or organizations outside of Notch for treatment purposes:

- Notch is authorized to provide all past and present health information including 42 CFR. Part 2 documents to other health care providers or agencies who participate in your care. This includes past medical records from outside organizations, prescriptions, drug and alcohol screening, diagnosis, and treatment.
- An individual release of information must be submitted for all transfer of care, family, friends, or other people that you wish to have access to your Medical Record information.

III. Assignment of Benefits

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

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

I understand I am responsible for any unpaid balances incurred due to my care at Notch.

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

Child's Name: _____DOB: _____

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 Notch in reliance of this consent if not previously cancelled, this consent will end three years after the last date of service 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 Notch 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 Notch agrees, Notch will not be able to provide services to (or the named patient with this signed consent.

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

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

Patient Signature: _____ Date: _____

Parental Signature: _____ Date: _____

Guardian Signature/ POA: _____ Date: _____

If you are a legal guardian/power of attorney of a patient, this document is not valid until legal paperwork is provided.