



School-Based Dental Center

Medical/Dental History Form

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 this form out **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

Child's Information

Today's Date: _____ Name of School: _____

Child's Name: _____ Date of Birth: _____ 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: _____ Phone Number: _____

Parent/Guardian Information

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

Primary Contact #: _____ Email: _____

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

Alternate Contact: _____ Relationship: _____

Alternate Contact #: _____ Email: _____

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

Insurance Information

Dental Insurance Carrier Name: _____ ID #: _____

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



Child's Name: _____ DOB: _____

Sex					
☐ Male ☐ Female					
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
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	

Income Information: Please check the appropriate box next to family size and corresponding household income range on the table below. As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

		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	\$15,960		\$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		

*Add \$5,500 per 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

- Have you ever been told your child needs antibiotics prior to going to the Dentist? ☐ Yes ☐ No
- 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	
☐	☐	ADHD	☐	☐	Diabetes
☐	☐	Asthma	☐	☐	Congenital Heart Defect
☐	☐	Autism	☐	☐	Convulsions/Epilepsy
☐	☐	Bleeding Disorder	☐	☐	Stomach, Liver or Kidney Problems
☐	☐	Cancer	☐	☐	Other:

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	
☐	☐	Iodine	☐	☐	Penicillin or other antibiotics
☐	☐	Latex	☐	☐	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.

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.



Child's Name: _____ DOB: _____

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.

I further understand this Consent covers only dental services provided at my child's school, Richford / Swanton Dental Clinic

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.



Authorization to Treat a Minor Without a Parent/Guardian Present

Northern Tier Centers for Health (NOTCH) requires authorization from the parent or legal guardian of a minor before providing non-emergency medical treatment for injuries or illnesses. This form provides NOTCH and its healthcare providers with your consent to assess and treat your minor child when you are not present.

I, _____, hereby authorize NOTCH and its providers to conduct medical/dental evaluations, diagnostic testing, and treatment for the minor child named below. I affirm that I am the parent and/or legal guardian of this child.

I understand and acknowledge that in my absence, medical and dental care may be rendered to my child without my direct supervision. I have been informed of the nature of the possible treatments and/or procedures listed below and understand the associated risks. I further understand that I am solely responsible for any charges, fees, or expenses related to the services provided.

This authorization is valid from the date of signature until the minor reaches 18 years of age unless revoked in writing prior to that time.

Minor Child's Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Any care beyond the outlined categories will require a parent or guardian to be present. Extractions and other advanced procedures will only be performed after a direct conversation with NOTCH. Additional consent forms must be signed for advanced treatments.

(Please check all that apply)

- ☐ All treatments
- ☐ Physical examination and/or first aid
- ☐ Medical and nursing management of acute or chronic illness
- ☐ Immunizations (including those required for school)
- ☐ Sports physicals
- ☐ Laboratory testing
- ☐ Dental screenings, cleanings, fillings, and x-rays as needed
- ☐ Treatment for dental pain, infection, or bleeding
- ☐ Administration of medications required for visit

Patient Signature (if applicable): _____ Date: _____

Parent Signature: _____ Date: _____

Guardian/POA Signature: _____ Date: _____

***If signing as a legal guardian or power of attorney, legal documentation must be provided for this form to be valid. ***



Vermont State Law

State of Vermont Guidelines: Informed Consent Individuals under the 18 years of age are minors under Vermont law [1 V.S.A. § 173]. Therefore, a minor's parent or guardian must provide informed consent for the minor to undergo medical treatment or a procedure with the following **exceptions**:

Minors of any age

- An individual of any age (including minors) may be treated without informed consent in an emergency [12 V.S.A. § 1909(b)].
- Minors of any age may give informed consent to:
 - Medical treatment associated with rape, incest, or sexual abuse. Health care providers are required to report such incidents to the Department for Children and Families within 24 hours [33 V.S.A. § 4911 et seq.].
 - Outpatient mental health treatment, including psychotherapy and counseling services, but not prescription drugs [18 V.S.A. § 8350].
 - Reproductive care, including contraceptive devices, termination of pregnancy, prenatal, delivery, and other pregnancy care [18 V.S.A. § 9493].

Minors 16 years of age and older

- Minors who are 16 years of age and older may consent to donate blood to a voluntary blood donation program where no compensation is received [18 V.S.A. § 9].

Minors 14 years of age and older

- Minors who are 14 years of age and older may apply for voluntary admission to a designated hospital for mental health related evaluation and treatment. Informed consent must be in writing and must include a representation that the person (a) understands that treatment will involve inpatient status, (b) desires to be admitted to the hospital, and (c) consents to voluntary admission without coercion or duress [18 V.S.A. § 7503].

Minors 14 years of age and younger

- Minors under 14 years of age may admit themselves to a hospital for mental health-related treatment by providing their own written informed consent and a written application from a parent or guardian [18 V.S.A. § 7503].

Minors 12 years of age and older

- Minors who are 12 years of age and older may give informed consent to testing and treatment for sexually transmitted diseases including HIV and AIDS, substance use, or substance use disorder. But, if a minor requires immediate hospitalization for treatment of any of these conditions, the parents shall be notified of the hospitalization [18 V.S.A. § 4226]

Confidentiality & Insurance Communications:

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, unless modified by State or other law, a minor who has the authority to consent to a health care service has the same authority to restrict the use and disclosure of the minor's protected health information (PHI) related to that service as if the minor were an adult [45 CFR § 164.502(g)(3)]

The HIPAA Privacy Rule requires that covered entities (including health insurance plans) permit an individual to request that the covered entity restrict uses or disclosures of PHI about the individual to carry out treatment, payment, or health care operations [45 CFR § 164.522(a)(1)(i)(A)]. A health insurance plan may, but is not required to, agree to a requested restriction, except that a health insurance plan must accommodate reasonable requests by individuals to receive communications of PHI from the health insurance plan by alternative means or at alternative locations if the individual clearly states that the disclosure of all or part of that information could endanger the individual [45 CFR § 164.522(a)(1)(ii); 45 CFR § 164.522(b)(1)(ii)]

The above information outlines the basic tenets of a minor's authority to restrict the use or disclosure of the minor's PHI related to a health care service (where the minor has the authority to consent to the health care service without a parent or guardian's consent) and why the minor may therefore request changes to how health insurance plan communications about that service are received.

[S.37~Amerin Aborjaily~Informed Consent Laws for Minors~4-12-2023.pdf](#)



**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.

