N★Co Family Health

Completion of Enrollment Form
is ***Required*** Each Year

Today's Date:

School-Based Health Center (SBHC)
2021-2022 Dental Enrollment Form

Student Information:		
First Name:	Last Name:	Full Middle Name:
Date of Birth:	Sex at Birth: ☐ Male ☐ Female	Street Address
Student's School:	Grade	Teacher/Homeroom:

North Country Family Health Center, as a Federally Qualified Health Center, *MUST* ask you to complete the following questions:

Race (please select): ☐ White ☐ Black or African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Unreported/Decline to Report	Ethnicity (please select): ☐ Non-Hispanic/Latino ☐ Hispanic/Latino
Preferred Language (student speaks): ☐ English ☐ Spanish ☐ Mandarin Chinese ☐ Sign Language ☐ Other:_____ Translation Assistance Needed: ☐ Yes ☐ No	
Where did the Student Sleep Last Night: ☐ At Home/Apartment ☐ Shelter ☐ Car/RV ☐ Street ☐ Do Not Have a Place ☐ With a Friend/Relative	

Parent/Guardian Information:	
Name:	Name:
Relationship to Student: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian – (please provide a copy of court order) ☐ Other:	Relationship to Student: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian – (please provide a copy of court order) ☐ Other:
Mailing Address if other than student's address:	Mailing Address if other than student's address:
Best Phone Number to Reach You: _____ ☐ Cell ☐ Home Okay to leave a message: ☐ Yes ☐ No	Best Phone Number to Reach You: _____ ☐ Cell ☐ Home Okay to leave a message: ☐ Yes ☐ No
Email:	Email:
Who Does the Student Live With: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Other:	
Who Will make Healthcare Decisions for This Student: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Other:	
Do we have permission to call the student's emergency contact you provided to the school: ☐ Yes ☐ No	

Primary Medical Insurance	**Dental Insurance**
☐ The Student ***Has*** Medical Insurance ☐ The Student ***Does Not*** have ***Medical*** Insurance Contact our Certified Application Counselor at 315-782-9450 x 8038 to help enroll your student in a healthcare plan that is right for you and your family.	☐ The Student ***Has Dental*** Insurance ☐ The Student ***Does Not*** have ***Dental*** Insurance Contact our Certified Application Counselor at 315-782-9450 x 8038 to help enroll your student in a healthcare plan that is right for you and your family.
Insurance Company Name:	Insurance Company Name:
Medical Policy #:	Dental Policy #:
Billing Address of Insurance Co:	Billing Address of Insurance Co:
Policy Holder's Name and Date of Birth:	Policy Holder's Name and Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:

Student Name: _____ Date of Birth: _____

☐ I have additional ***Medical*** Insurance (name of insurance co.):	☐ I have additional ***Dental*** Insurance (name of insurance co.):

Dental School-Based Health Center Enrollment:

Student's Dentist Name: ☐ My Student Doesn't Have a Regular Dentist

North Country Family Health Center Policies and Consents

Consent for School-Based Health Dental Services 2021-2022

I authorize my student to receive services provided by the staff of the North Country Family Health Center (NCFHC) School-Based Dental Program. Services may include, but are not limited to: preventative dental services; I give my consent for NCFHC staff to have access to the student's school health records and copies of the student's most recent physical/dental exam. I give my permission for the release of the student's dental summaries to be shared with his/her dental provider. I understand that every effort will be made to contact me prior to services, however I understand this may not always be possible. The staff of NCFHC believes that parental involvement is essential in keeping children healthy and will encourage each student to involve his or her parents in healthcare decisions. We encourage parents/guardians to visit/call the SBHC any time.

North Country Family Health Center Policies and Consents

Permission to Disclose to Family or Other Individuals

Pediatric Consent

Non-Parental Consent: For pediatric patients under the age of 18 you may designate another person to attend visits and authorize treatment decisions.

☐ **No**, I do not give consent for another adult to attend, give consent, and make treatment decisions in my absence.

☐ **Yes**, if I am unable to attend my child's appointments, I give consent for the following adult(s) to attend and to give consent for dental services and to make treatment decisions for my child in my absence. This consent is valid for one year from date of signature unless revoked in writing prior to expiration.

Name of Individual(s):	Relationship to Student:

Finance Policy:

North Country Family Health Center's (NCFHC) School-Based Health Program serves all students whether they are covered by insurance or not. Services provided in the school-based setting have NO out of pocket costs. However, if the student requires services we do not provide at the SBHC – outside tests or labs – there may be out of pocket costs incurred. If you have insurance, we will bill your insurance company for you. If you do not have insurance, we can assist you with obtaining insurance coverage.

I authorize NCFHC and its representatives to release any information they obtain, including medical information to your insurance company or their representatives to process claims for payment. As applicable, I authorize my insurance provider to pay North Country Family Health Center, Inc. for services rendered.

Notice of Privacy Practices:

- I have been given the opportunity to review or receive a copy of North Country Family Health Center's (NCFHC) Notice of Privacy Practices which describes how NCFHC may use and disclose my student's protected health information following applicable state and federal law.
- I understand that this may include disclosures of information to my student's insurance carrier(s) to issue payment directly to NCFHC.
- I understand that I have the right to receive a copy of my student's dental information or to request restrictions on the use of my student's protected health information.
- I understand that NCFHC may engage business associates to assist in my student's coordination of care including afterhours telephone coverage and call reminder service.
- I understand any reminder calls, texts, or email correspondence may be recorded to improve customer service and patient care.

My Signature Means:

I have reviewed and completed the Consent for School-Based Dental Services and Permission to Disclose to Family or Other Individuals sections. I understand that when I designate another person to authorize a treatment decision, North Country Family Health Center may disclose protected health information to the authorized person(s). I have reviewed North Country Family Health Center's Finance Policy, Consent for Treatment, and Notice of Privacy Practices.

Student Name: _____ Date of Birth: _____

I have been given the opportunity to ask questions and all of my questions have been answered fully and satisfactorily. ***I understand that my consent will remain in effect as long as the student is enrolled in NCFHC's SBHC Program, unless I notify NCFHC in writing. I understand that I may revoke my consent at any time.***	
Printed Name of Legally Authorized Representative:	State Relationship to Student:
Signature of Legally Authorized Representative: Date:	

Student Name: _____ Date of Birth: _____

Medical/Dental History Form:

Has your student had any history of/or conditions related to any of the following:
☐ ADHD/Mental Health Issues ☐ Asthma ☐ Autism ☐ Cancer ☐ Cardiac Issues ☐ Chicken Pox ☐ Diabetes
☐ Growth Problems ☐ Kidney/Urinary Issues ☐ Latex Allergy ☐ Rheumatic Fever ☐ Seizures ☐ Thyroid Issues
☐ Tuberculosis ☐ Other:

Last Physical Exam was on (provide date):

Past Surgeries: ☐ No ☐ Yes (please list):

Past Hospitalizations: ☐ No ☐ Yes (please list):

Does the Student See a Healthcare Specialist: ☐ No ☐ Yes (name & phone #):

Allergies: ☐ No ☐ Yes (please list what allergen and reaction to each item):

Daily Medications: ☐ No ☐ Yes (please list):

Has the student or anyone who lives in your house ever been exposed to or had contact with anyone with a positive tuberculosis screen or active tuberculosis disease: ☐ No ☐ Yes (please list name):

Does the student have developmental delays or problems? ☐ No ☐ Yes (please list):

Does the student have any current dental problems? ☐ No ☐ Yes (please list):

Has the student had problems with dental treatment in the past? ☐ No ☐ Yes (please explain)

How many individuals smoke in the house:

Has the student had any injury to the mouth or teeth? ☐ No ☐ Yes (please explain):

What type of water does the student drink? ☐ City Water ☐ Well Water ☐ Bottled Water ☐ Filtered Water

Family History:
Check any of the following conditions a relative has had, please include both mother's and father's side of the family:

	Mom	Dad	Sister Brother	Aunt Uncle	G-Parent		Mom	Dad	Sister Brother	Aunt Uncle	G-Parent
Allergies/eczema						Migraines					
Asthma						Obesity					
Cancer						Stomach/GI Issues					
Diabetes						Stroke					
High Blood Pressure						History Unknown					
Kidney Disease						Other:					
Mental Health Issues											

North Country Family Health Center, Inc

CONSENT FOR RELEASE OF MEDICAL INFORMATION

****Complete this Form if the Student is NOT a Current Medical Patient of North Country Family Health Center to Ensure Coordination of Care with your Child's Primary Care Provider****

Student's Name:	Student's Date of Birth:	Student's SS#:
Student's Address:		

I, the student's authorized representative, request that health information regarding my student's care and treatment be released as set forth on this form. I understand that with some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. I have the right to revoke this authorization at any time by writing to the student's primary care provider. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Signing this authorization is voluntary. I understand that generally my student's treatment will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

Student's Primary Care Provider's Name:

Name and Address of Provider of Whom this Information will be Disclosed:
North Country Family Health Center, Inc., 238 Arsenal Street, Watertown, NY 13601

Purpose of Release of Information:
Collaboration and continuity of care between student's primary care provider and student's School-Based Health Center.

Type of Information to be Released (check all that apply):

- ☐ Clinical records related to the most recent physical exam, current diagnosis, and treatment of medical issues.
- ☐ Clinical records of mental health treatment
- ☐ HIV/AIDS-related information
- ☐ Records from alcohol/drug treatment programs

Unless previously revoked by me in writing, this release is effective from the date below to one year after signing.

Name of Authorized Person Signing the Form:	Relationship to the Student:
Signature of Authorized Person:	Date:

CONSENT FOR RELEASE OF DENTAL INFORMATION

****Complete this Section if the Student is NOT a Current Dental Patient of North Country Family Health Center to Ensure Coordination of Care with your Child's Dentist****

Student's Dentist's Name:

Name and Address of Provider of Whom this Information will be Disclosed:
North Country Family Health Center, Inc., 238 Arsenal Street, Watertown, NY 13601

Purpose of Release of Information:
Collaboration and continuity of care between student's dentist and student's School-Based Dental Program.

Type of Information to be Released:
Clinical records related to the most recent dental exam, current diagnosis, and treatment of dental issues.

Unless previously revoked by me in writing, this release is effective from the date below to one year after signing.

Name of Authorized Person Signing the Form:	Relationship to the Student:
Signature of Authorized Person:	Date: