

School-Based Dental Program

Welcome . . .

Your school district offers an in-school preventative dental health program through North Country Family Health Center for all students.

What is the School-Based Dental Program?

The school-based dental program provides dental services to students, Pre-K through 12th grade, where they are – in school. The dental program operates within the school building while the school is in session and serves the students enrolled in the school district. The dental program uses portable equipment that is easily set up and broken down.

What Services are Offered?

Preventive services offered are screenings, cleanings, fluoride treatments, and sealants. Additionally, dental education is provided to individual students and can be provided in classroom sessions as well. Services are provided by a New York State licensed Dental Hygienist on the staff of North Country Family Health Center.

What Does it Cost?

There are NO out of pocket expenses for preventative services. If there is insurance associated with the student, North Country Family Health Center will bill the insurance company to cover expenses.

Who is Eligible for the Program?

All students may receive preventive dental care. If you have a family dentist, your student can still get preventive care (dental screenings, cleanings, sealants, and fluoride treatments) at school.

There are no eligibility or income requirements.

How do I Enroll my Student?

Please complete the attached **Dental Enrollment Form** and return it to your student's school.

How are Appointments Scheduled?

Once the enrollment form has been returned to school, you will be contacted before your student is scheduled for a visit. Your student will be called down to the dental program area for their appointment. We always try to avoid a core subject or special activity when scheduling.

Can I Come to My Student's Appointment?

Parents are always welcome to come, but it is not necessary. Appointments typically last 20 minutes. After each visit, the student will receive a goody bag filled with oral hygiene supplies, and a note discussing the outcome of the appointment. If there are any concerns a phone call home will be made.

It's important to keep your teeth healthy!





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

Today's Date:

**School-Based Health Center (SBHC)
2022-2023 Dental Enrollment Form**

Student Information:		
Last Name:	First Name:	Full Middle Name:
Date of Birth:	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Street Address
Student's School:	Grade:	Teacher/Homeroom:
North Country Family Health Center, as a Federally Qualified Health Center, <i>MUST</i> ask you to complete the following questions:		
Race (please select): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Unreported/Decline to Report		Ethnicity (please select): <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino
Preferred Language (student speaks): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Mandarin Chinese <input type="checkbox"/> Sign Language <input type="checkbox"/> Other: _____ Translation Assistance Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Where did the Student Sleep Last Night: <input type="checkbox"/> At Home/Apartment <input type="checkbox"/> Shelter <input type="checkbox"/> Car/RV <input type="checkbox"/> Street <input type="checkbox"/> Do Not Have a Place <input type="checkbox"/> With a Friend/Relative		
Parent/Guardian Information:		
Name:	Name:	
Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Parent <input type="checkbox"/> Guardian – (please provide a copy of court order) <input type="checkbox"/> Other:	Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Parent <input type="checkbox"/> Guardian – (please provide a copy of court order) <input type="checkbox"/> Other:	
Mailing Address if other than student's address:	Mailing Address if other than student's address:	
Best Phone Number to Reach You: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Okay to leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No	Best Phone Number to Reach You: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Okay to leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who Does the Student Live With: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian <input type="checkbox"/> Step Parent <input type="checkbox"/> Other:		
Who Will make Healthcare Decisions for This Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian <input type="checkbox"/> Step Parent <input type="checkbox"/> Other:		
Do we have permission to call the student's emergency contact you provided to the school: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Medical Insurance		Dental Insurance
<input type="checkbox"/> The Student Has Medical Insurance <input type="checkbox"/> 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.		<input type="checkbox"/> The Student Has Dental Insurance <input type="checkbox"/> 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: _____

<input type="checkbox"/> I have additional Medical Insurance (name of insurance co.):	<input type="checkbox"/> I have additional Dental Insurance (name of insurance co.):
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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 2022-2023

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

Student Name: _____

Date of Birth: _____

Practices.

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											



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:		
<p>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.</p>		
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): <ul style="list-style-type: none"> <input type="checkbox"/> Clinical records related to the most recent physical exam, current diagnosis, and treatment of medical issues. <input type="checkbox"/> Clinical records of mental health treatment <input type="checkbox"/> HIV/AIDS-related information <input type="checkbox"/> Records from alcohol/drug treatment programs 		
Unless previously revoked by me in writing, this release is effective from <u>the date below to one year after signing.</u>		
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 <u>the date below to one year after signing.</u>	
Name of Authorized Person Signing the Form:	Relationship to the Student:
Signature of Authorized Person:	Date: