N★Co North Country Family Health Center, Inc.

School-Based Dental Program

Welcome . . .
Your School District offers an in-school Preventative Dental Program through North Country Family Health Center for ALL students.

What is the School-Based Dental Program?
The School-Based Dental Program provides preventative 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?
Preventative 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 costs for preventative services provided within the School-Based Dental Program. If there is insurance associated with the student, North Country Family Health Center will bill the insurance company to cover costs.

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. If you have questions, please call 315-779-5611.

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. At the time of the appointment, 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?
Yes, parents are always welcome to come, but it is not necessary. Appointments typically last 20-30 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 This Enrollment Form
Is ***Required*** Each Year

Today's Date:

School-Based Dental 2024-2025 Enrollment Form

Student Information:

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

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

Parent/Guardian # 1 Information:	**Parent/Guardian # 2 Information:**
Name:	Name:
Relationship to Student: ☐ Father ☐ Mother ☐ Step-Parent ☐ Guardian (Please Provide a Copy of Court Order) ☐ Other (Please Define):	Relationship to Student: ☐ Father ☐ Mother ☐ Step-Parent ☐ Guardian (Please Provide a Copy of Court Order) ☐ Other (Please Define):
Mailing Address (If Different than Student):	Mailing Address (If Different than Student):
Best Phone Number to Reach You: ___________________________ ☐ Cell ☐ Home Okay to Leave a Message/Text: ☐ Yes ☐ No	Best Phone Number to Reach You: ___________________________ ☐ Cell ☐ Home Okay to Leave a Message/Text: ☐ Yes ☐ No

Who Does My Student Live With: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Step Parent ☐ Other:

Who Will Make Healthcare Decisions for My Student: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Step Parent ☐ Other:

Do We Have Permission to Call the Student's Emergency Contact You Provided to the School: ☐ Yes ☐ No

North Country Family Health Center, as a Federally Qualified Health Center, MUST Ask You to Complete the Following Questions (PLEASE FILL OUT ALL SECTIONS BELOW RESPONDING FOR YOUR STUDENT):

Household Size & Income (Enter Child's Family Information):
Number of People in the Household: _____________ Income $____________________________ ☐ Week ☐ Month ☐ Year

What Gender Does Your Student Identify as:
☐ Male ☐ Female ☐ Transgender Male: Female to Male ☐ Transgender Female: Male to Female
☐Gender Non-Conforming (Neither Exclusively Male nor Female)
☐ Additional Gender Category /Other (Please Specify): ____ ☐ Choose Not to Disclose

Student's Sexual Preference/What Does Your Student Think of Themselves as:
☐ Straight/Heterosexual ☐ Gay/Lesbian/Homosexual ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not to Disclose

Student's Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐Choose Not to Disclose

Student's Ethnicity: ☐None ☐Hispanic or Latino/Spanish ☐Latin American/Latin ☐Puerto Rican ☐South American ☐Spaniard

Student's Race: ☐White ☐Black or African American ☐ Asian ☐American Indian or Alaskan Native ☐Native Hawaiian/Pacific Islander

Student's Primary Language: ☐English ☐Spanish ☐Other (Please Specify):

Student Name: ____ **Date of Birth:** ________________

Primary Medical Insurance	Dental Insurance
☐ The Student ***Has*** Medical Insurance ☐ The Student ***Does Not*** Have ***Medical*** Insurance Please 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 Please 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 Company:	Billing Address of Insurance Company:
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 #:
☐ I Have Additional ***Medical*** Insurance (Name of Insurance):	☐ I Have Additional ***Dental*** Insurance (Name of Insurance):

Please Complete Dental History Below:

Does Your Student Take Daily Medications: ☐ No ☐ Yes (Please List):

Does Your Student Have Any Allergies: ☐ No ☐ Yes (Please List):

Does Your Student Have Any Current Dental Problems? ☐ No ☐ Yes (Please List):

Has Your Student Had Problems with Dental Treatment? ☐ No ☐ Yes (Please Explain):

Has Your Student Had Any Injury to the Mouth or Teeth? ☐ No ☐ Yes (Please Explain):

Does Anyone in the Home Smoke or Vape? ☐ No ☐ Yes

North Country Family Health Center Policies and Consents

Consent for School-Based Dental Services: I authorize my student to receive preventative dental services provided by the staff of North Country Family Health Center's (NCFHC) School-Based Dental Program. I give my consent for NCFHC staff to have access to my student's school health records and copies of my student's most recent dental exam. I consent to photographs being taken of the student for inclusion in their confidential electronic medical record for diagnosis and treatment only. I give my permission for the release of my student's dental summaries to be shared with his/her dental provider and/or the school nurse to coordinate his or her care. 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 or call the School-Based Dental Program at any time. ***If I have questions about enrolling my student and the School-Based Dental Program, I will contact NCFHC's Dental Director, Nicole Quintin at (315) 782-9450 x8094.***

Permission to Disclose to Family or Other Individuals (Non-Parents/Guardians): For pediatric patients under the age of 18 you may designate another person to attend visits and authorize treatment decisions. 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). Parents do not need to be included here.

- ☐ **No**, I do not give consent for another adult to attend, give consent for services, and/or make treatment decisions in my absence.
- ☐ **Yes**, I give consent for the following adult(s) to attend, give consent for services, and/or make treatment decisions for my child in my absence. This consent is valid for one year from the date of signature unless revoked in writing prior to expiration. I understand that I may revoke my consent at any time.

Student Name: ____ **Date of Birth: ________________**

Name of Individual(s):	Relationship to Student:

Finance Policy: North Country Family Health Center's (NCFHC) School-Based Dental 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 within the School-Based Dental Program such as 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, please call our Certified Application Counselor at 315-782-9450 x 8038. .I authorize NCFHC and its representatives to release any information they obtain, including medical information, to my 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: 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 is posted in the SBHC. You may also visit www.nocofamilyhealth.org for a copy.

- 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, Parkview Pharmacy, and call reminder service including text messages.
- I understand NCFHC may use letters, reminder calls, text messages, or secure email correspondences to communicate with me regarding my student's care. I authorize NCFHC to communicate with me via these methods and understand this correspondence may contain PHI.
- I understand NCFHC may use computer assisted technologies guided by our internal policy & procedures to enhance my care, with all data processed securely and all clinical decisions made by a qualified healthcare provider.

My Signature Below Means:

I have reviewed, completed, and agreed to the Consent for School-Based Dental Services, Permission to Disclose to Family or Other Individuals, Finance Policy, and Notice of Privacy Practices sections.

Printed Name of Legally Authorized Representative:	Relationship to Student:
Signature of Legally Authorized Representative:	Date:

CONSENT FOR RELEASE OF MEDICAL AND DENTAL INFORMATION

Complete this Form if Your Student is **NOT** a Current Medical or Dental Patient of North Country Family Health Center

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 behavioral 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 my 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.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Complete This Section if Your 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

My 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 my student's primary care provider and my 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

- ☒ All immunizations
- ☒ Past two years of lab tests, imaging, and procedures
- ☒ Past year of behavioral health treatment

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

CONSENT FOR RELEASE OF DENTAL INFORMATION

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

My 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 your student's Dentist and your 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:**