SCHOOL-BASED DENTAL PROGRAM

GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

STUDENT DENTAL ENROLLMENT

Phone: 207-874 -2141
Fax: 207-874-2164

Dear Parent/Guardian ~

Greater Portland Health (GPH), in partnership with Portland, Westbrook, and South Portland Public Schools, offers dental care on site at select schools.

Please complete and sign this dental enrollment form and the Authorization for Disclosure of Information to allow your child to access dental services at their school. This is true even if your child is a patient of GPH.

With your permission, a dental professional will provide the services* you indicate below. Please check off all services you want your child to receive:

☐ Yes, I would like my child to get a dental screening

☐ Yes, I would like my child to get a dental cleaning

☐ Yes, I would like my child to get a fluoride treatment

*A report of the oral health services performed will be sent home with your child

Follow-up treatment is provided by a GPH dentist at the clinic located in Portland High School. Treatment may include, but is not limited to, dental exam, diagnostic x-rays, fluoride, fillings, crowns, and extractions.

If you have any questions, please reach out to:

Jenna MacDonald, GPH Dental Practice Manager
Phone: 207-874-2141

STUDENT INFORMATION

LEGAL LAST NAME _____

LEGAL FIRST NAME _____

LEGAL MIDDLE NAME _____

PREFERRED FIRST NAME _____
chosen name, nickname, goes-by name, "Please call me by this name"

DATE OF BIRTH: ___/___/___
Month Day Year

SCHOOL _____

TEACHER _____

GRADE _____

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YOUR CHILD'S INSURANCE COVERAGE

For children who do not have dental insurance or if your insurance does not cover the indicated dental services, you may receive a bill for services provided. There is a sliding fee scale available to all who qualify. Financial assistance counselors are available to assist you in determining insurance options and payment plans. Screenings and fluoride applications are currently funded by a grant so will not be billed to you.

Does your child have MaineCare (Medicaid)? ☐ Yes ☐ No ☐ I'm not sure

If yes, what is your child's MaineCare ID# _____

Does your child have other Dental Insurance? ☐ Yes ☐ No ☐ I'm not sure

Name of Subscriber	Date of Birth	Relationship to Patient
	___/___/___	

Name of Insurance Company	Member ID #	Group ID #	Effective Date

Address	City	State	Zip

Who is your child's Primary Care Physician:_____
☐ My child does not currently have a doctor.

Who is your child's Dentist:_____
☐ My child does not currently have a dentist.

When was the last time your child went to a Dentist?
☐ In the past year ☐ Over a year ago ☐ Never Before

Does your child have any allergies? If Yes, please list: _____

List any medications your child takes: _____

Please list any history of surgeries:_____

Does your child have any of the following: ***Please select all that apply.***

☐ ADD/ ADHD
☐ AIDS/ HIV/Hepatitis
☐ Anxiety
☐ Asthma
☐ Autism/Asperger's
☐ Birth Defects
☐ Cerebral Palsy
☐ Cleft Lip / Palate
☐ Cancer/Tumors
☐ Congenital Heart Disease
☐ Diabetes Type_____
☐ Epilepsy/ Seizures
☐ Kidney Disorder
☐ Liver Disorder
☐ Speech /Hearing problems

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OTHER STUDENT INFORMATION

The information you share in this section will not negatively affect your child's care in any way. It is for demographic purposes only. We collect this information to ensure we recognize and respect all patients regardless of gender, sexual orientation, race, or ethnicity.

Gender Identity:
☐ Male
☐ Female
☐ Transgender Male
☐ Transgender Female
☐ Nonbinary
☐ Decline to Answer
☐ Not listed
(please specify below):
_____

Legal Gender:
☐ Male
☐ Female
☐ X or Nonbinary
☐ Intersex

Sex Assigned at Birth:
☐ Male
☐ Female

Pronouns:
☐ She/Her/Hers
☐ He/Him/His
☐ They/Them/Theirs
☐ Decline to Answer
☐ Not listed
(please specify below):
_____

Sexual Orientation:
☐ Straight
☐ Lesbian or gay
☐ Bisexual
☐ Pansexual
☐ Decline to Answer
☐ Not listed
_____

Race:

☐ **White**
Portugal, Germany, Poland, Bosnia, Middle Eastern Countries

☐ **Black, African, African American**
Haiti, Jamaica, Kenya, Congo, etc.

☐ **Pacific Islander**
Samoa, Guam, Micronesia, Tahiti, Palua, etc.

☐ **Asian**
China, Philippines, Bangladesh, Nepal, Pakistan, Vietnam

☐ **Native Hawaiian**
Native of any Hawaiian Island

☐ **South/Central/North American Indian, Alaska Native**
Native American, Penobscot, Passamaquoddy, Maliseet, Micmac, Abenaki, Inuit, Mayan, Incan, Puerto Rican, Miskito, Chatino, etc.

☐ **Multiracial**
More than one race/ethnicity

☐ **Declined to Specify**

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Preferred Language (Circle One):

English Spanish French Arabic Portuguese Somali Cantonese Lingala

ASL (Hearing Impaired) Kinyarwanda Kirundi Swahili Other: _____

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PARENT/LEGAL GUARDIAN CONTACT INFORMATION

Parent/Guardian Last Name _____ Parent/Guardian First Name _____ Relationship/Role _____ Date of Birth _____

Address _____ Telephone # _____

Are you a patient of Greater Portland Health ?

☐ **YES** ☐ **NO**

Parent/Guardian Email Address _____

Parent/Guardian & Student Home Address (if different than above):

Street, Apt./Unit # _____ City _____ State ____ Zip Code ____

By signing this form, I acknowledge that:

I consent to having my child receive the dental services that I have indicated above without a parent or guardian present for the duration of my child's enrollment in a Portland, Westbrook or South Portland School.

I understand GPH's School-Based Dental Program is a separate entity from the school and from the school nurse's office. It provides dental assessments and a range of oral health care treatment in a school-based location while engaging in communications with other healthcare providers who may also be involved in the care of my child.

☐ Yes, I reviewed GPH's **Notice of Privacy Practices**, which is available on our website by scanning this QR code.

_____ _____

Signature of Patient or Parent/Legal Guardian **Date Signed**