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 school districts in Cumberland County, offers dental care on site at select schools.

Please complete and sign this Dental Enrollment Form, the Consent to Treat Form, and the Authorization for Disclosure of Information Form to allow your child to access dental services at their school. You must do this 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
- ☐ Yes, I would like my child to get dental sealants to prevent cavities in their permanent teeth (if appropriate).

*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 call (207) 874-2141, ext. 8401, or send an e-mail to jmacdonald@greaterportlandhealth.org.

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 STUDENT'S DENTAL INSURANCE COVERAGE

If your child has dental insurance, including MaineCare, the insurance will be billed. Your family will not be billed for any denied claims or if your child is uninsured.

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 private/commercial Dental Insurance? ☐ Yes ☐ No ☐ I'm not sure

_____ Name of Subscriber

_____ / _____ / _____ *Month Day Year* Date of Birth

_____ Relationship to Patient

_____ Name of Insurance Company

_____ Member ID #

_____ Group ID #

_____ Effective Date

_____ Address

_____ City _____ State _____ Zip

STUDENT HEALTH INFORMATION

Does your child have any allergies? Y or N (circle one) If yes, please list them:_____
List any medications your child takes: _____
Please list any history of surgeries: _____
Does your child have any of the following conditions? Please check off 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

Who is your child's Primary Care Provider:_____
☐My child does not currently have a primary care provider.

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

If your child has a dentist, when was the last time they went to their Dentist?
☐ In the past year ☐ Over a year ago ☐ Never Before

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STUDENT DEMOGRAPHIC 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.

Legal Sex (check one):

☐ Male

☐ Female

Is there anything else you would like to share with us about your student's background that could affect how we care for them as a patient?

_____

_____

How many individuals are living in your household?_____

Total Annual Household Income: _____

Preferred Language (Circle One):

English Spanish French Arabic Portuguese Somali Cantonese Lingala

Kinyarwanda Kirundi Swahili Other: _____ ASL (Hearing Impaired)

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

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PARENT/LEGAL GUARDIAN CONTACT INFORMATION

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

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

Telephone # _____

Are you a patient of Greater Portland Health ?

☐ **YES** ☐ **NO**

Parent/Guardian Email Address _____

Student Home Address (if different from Parent/Guardian's):

_____

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 Cumberland County school district with which GPH partners.

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.**

☐ **Yes, I have signed the General Consent to Treatment and Authorization for Disclosure of Information.**

_____ _____

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

GREATER PORTLAND HEALTH

CARING FOR THE WHOLE COMMUNITY

Greater Portland Health School-Based Health Centers and Children's Oral Health

Program Authorization for Disclosure of Information

By signing below, I am acknowledging and agreeing to the following, with respect to my child's enrollment in the Greater Portland Health (GPH) Children's Oral Health Program and/or School-Based Health Center (SBHC) Program and the disclosure of my child's health record and related information:

- I have received and read GPH's Notice of Privacy Practices which advises regarding the uses and disclosures that may be made of the health information in my child's health record, in accordance with HIPAA confidentiality standards.
- I authorize GPH to access my child's school health record, including but not limited to physical, behavioral and counseling records if any, and any related information, for treatment-related purposes or as otherwise required or allowed by law as determined by GPH.
- I authorize the GPH to provide the School (including the nurse and social workers) with information from the GPH records as necessary and appropriate for treatment-related purposes or as otherwise required or allowed by law as determined by GPH.
- I authorize the GPH to share the information in GPH records (including school health records if included in the GPH record) with other treating physicians and providers including primary care providers, dentists, and mental health professionals, to facilitate the delivery of health care for my child.
- I authorize my child's primary care provider, dentist, and mental health professional ("Third Party Providers") to provide health information and records to the GPH to facilitate the delivery of health care by the GPH for my child. I understand that I may be asked by such Third-Party Providers to execute a separate authorization to allow disclosure of the records regarding treatment by the Third-Party Providers.
- I authorize the GPH to release information from GPH records as necessary for billing insurers or other payors.
- I understand and agree that: (i) This authorization is valid from the date of signing unless a shorter duration is provided here; and (ii) I may revoke this authorization at any time by submitting written notice of the withdrawal of the authorization, except to the extent where the GPH has relied upon the original consent.

✍ **Parent/Guardian Signature:**_____Date:_____

Print Name: _____Relationship_____

GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

GENERAL CONSENT TO TREATMENT

100 Brickhill Ave, Suite 301, South Portland, Maine 04106
P. (207) 874-2141 F. (207) 761-3738

Patient Name:_____ **Date of Birth:**_____

Greater Portland Health ("GPH") is a community health center providing integrated medical care for physical and behavioral health, including HIV/AIDS, and dental services, to everyone in the community. GPH uses an electronic health record that includes all your medical information in one place. To give you the best care possible, GPH providers may view any portion of your medical record relevant to your treatment, including your physical, mental health, substance use and/or dental records.

1. **General Consent to Treatment:** By signing below, I authorize health care providers at GPH to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care (including emergency treatment), services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo any procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recovery, the likelihood of success, other options including relevant risks or side effects to those alternatives, as well as information about possible results of not choosing to undergo the recommended treatment.

2. **Right to Refuse Treatment:** In giving my general consent to treatment, I understand that I may refuse any examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my health care provider(s) and that I remain responsible for decisions about my own healthcare and the consequences of those decisions.

3. **Responsibility of Payment:** I understand that I must pay GPH for any charges resulting from my treatment. I request that payment of authorized covered benefits be made on my behalf to GPH for such services. I understand GPH may release health information about me including information related to HIV/AIDS, substance abuse (except information limited by law), and mental health treatment to my health insurance carrier(s) in order to verify those benefits.

4. **Release of Health Care Information:** I understand that, subject to certain conditions, I may ask to limit disclosures, receive confidential information by giving GPH an address, phone number or other means of receiving the information, see or obtain copies of my protected health information upon written request, and that I have other rights with respect to my health information as set forth in the Notice of Privacy Practices.

5. **Notice of Privacy Practices:** I understand that GPH must keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, coordinating care for me, or for GPH's necessary internal operations.

6. **Insurance**: If I have active insurance coverage, I need to make sure my insurance plan has my GPH primary care provider (PCP) listed for proper billing and specialty care access. I understand that GPH has the right to contact my insurance plan provider to provide updated information if the primary care provider listed is not correct.

7. **HealthInfoNet:** HealthInfoNet is a secure, standardized electronic system where health care providers around Maine can share important patient information, giving them the tools needed to make more informed treatment decisions. This is an opt-out program. If you would like to learn more or opt-out, ask one of our front desk Patient Service Representatives.

8. **Rules for Proper Behavior:** GPH must be a safe and respectful environment for everyone – clients, staff, visitors and volunteers. Behaviors which make the clinic space unsafe, abusive, or threatening is unacceptable. Such behaviors will result in appropriate actions by GPH, including creating collaborative care contracts and possible termination from the practice.

9. **Grievance rights**: I am aware of my grievance rights outlined in Greater Portland Health's Grievance Handling Policy.

10. **Signature:** By signing below, I agree that I have read and understand the information provided above. If I have any questions regarding my consent, I will ask my provider before signing this form.

Patient Signature_____ **Date** _____
(If under 18, a parent or legal guardian must sign)