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

Where does your child usually receive their care? ___ Northern Light Health ___ InterMed
___ MaineHealth ___ Martin's Point ___ Greater Portland Health Other:_____

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 # _____

Parent/Guardian Email Address _____

Are you a patient of Greater Portland Health ?

☐ **YES** ☐ **NO**

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 have received and reviewed GPH's Notice of Privacy Practices, included in this enrollment form.**
- **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.**

_____ _____

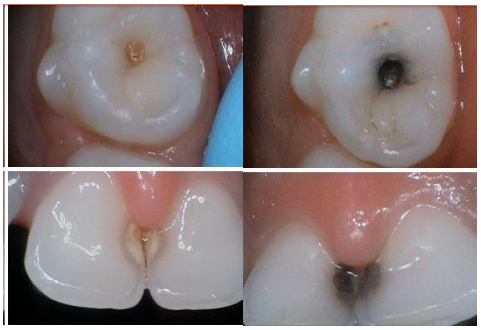
Signature of Patient or Parent/Legal Guardian **Date Signed**

GREATER PORTLAND HEALTH

INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE (SDF) TREATMENT

WHAT IS IT? SDF is a multipurpose antibiotic liquid we use on teeth. We will not place SDF on front teeth.

PROCEDURE: Dry, apply 1 min, wipe it off, fluoride varnish (optional)
Metallic/Bitter taste subsides quickly
Reapply every 6 months or treat with fillings



BENEFITS:

- SDF can help stop or slow tooth decay
- SDF can help relieve tooth sensitivity
- SDF can help patients who are very young, fearful, or have special needs that would require sedation for traditional treatment.

SIDE EFFECTS/CONTRAINDICATIONS/RISKS:

- SDF will stain the cavity we are treating permanently black.
- Tooth-colored fillings and crowns may discolor if SDF is applied to them
- If SDF is applied to the gums or skin, a brown or white stain may appear and will disappear in 1-3 weeks.
- **Do not use SDF if you are allergic to silver and/or have painful sores or raw areas on your gums or anywhere in your mouth**
- For deep cavities, the risk of a pulpal reaction increases. If this occurs, it can be managed by root canal or tooth removal depending on the situation. In some instances it may be worth applying despite the risk of this response if it allows for a chance to save the tooth.

- Use of SDF may or may not eliminate the need for dental fillings or crowns to repair the tooth.
- Additional procedures might be needed if decay is deep or cannot be stopped with SDF.
- No treatment will result in continued tooth deterioration. Symptoms may develop or increase.
- Alternatives include, fillings, crowns, extraction, or referral for advanced treatment/management

I hereby acknowledge that I have either read this consent agreement or it was explained to me. I understand this consent and the meaning of its contents, including the benefits and risks of SDF. All questions were answered in a satisfactory manner.

☐ **Yes, I consent to my child receiving SDF treatment.**

☐ **No, I do not consent to my child receiving SDF treatment.**

Patient's Name:_____ Date of Birth: _____

Patient/Parent's Signature: _____Date _____

Dental Provider Signature: _____ Date _____

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed, your rights with respect to your protected health information ("PHI"), how to file a complaint concerning a violation of the privacy or security of your PHI, or of your rights concerning your PHI. You have a right to copy this Notice (in paper or electronic form) and to discuss it with Greater Portland Health's ("GPH") Privacy Officer at 207-874-2141 if you have any questions.

This Notice applies to all PHI, including, if applicable, Substance Use Disorder ("SUD") Treatment information.

Uses and Disclosures of Your PHI:
When you seek health care services from GPH, a record of the interaction is documented. This record may contain your symptoms, examination and test results, diagnosis, treatment, and a plan for your future care/services. This information is part of your health/medical record and is an essential part of the health care/services we provide to you. The information about you in the record is sometimes referred to as PHI and GPH is obligated by law to protect the privacy of the PHI. Any uses and disclosures of your PHI not described in this notice will only be permitted with notice to you and with your advanced written consent, which you have the right to revoke at any time. An example involves marketing activities.

We may use and disclose your PHI without separate written authorization:
- For planning and providing your care and treatment,
- In communication with health professionals who contribute to your care,
- For verification to third-party payers (insurance companies) that services were provided,
- In performing heath care operations, including quality assessments regarding the care we render and the outcomes we achieve,
- To make you aware of services and treatments that may be of interest to you,
- To comply with state and federal laws that require us to disclose your PHI, and
- If your PHI includes SUD records generated in connection with a SUD program supported by federal funding, and if you have executed an authorization form for the disclosure of your other PHI to a third party, the authorization is sufficient by law to allow the disclosure of the SUD information.

Special Restrictions:
We shall not disclose PHI or testify regarding the content of your confidential records in any civil, administrative, criminal, or legislative proceedings without your specific written consent or a court order. The production of PHI for court proceedings (based on a subpoena or other legal mandate and a Court Order) will not occur without our first giving notice to you to allow you an opportunity to challenge the production or to otherwise be heard, if such notice and/or opportunity is required by federal law.

Disclosures Regarding Substance Use Disorder Services in a "Part 2" Program. If your PHI includes SUD records generated in connection with a "Part 2" Program (i.e. a SUD program supported by federal funding), any allowed or mandated disclosure for treatment, payment or health care operations to another provider or SUD Program, may be further disclosed by that program or health care provider if and to the

extent allowed by federal law, without requiring a separate written consent from you. If you execute an authorization form for the disclosure of your PHI to a third party, and it covers both general PHI as well as SUD records, a separate consent form will not be necessary for SUD disclosures.

Your Rights Regarding Your Health Information.
Although your health record is the physical property of GPH, the PHI belongs to you. Under Federal Privacy Rules, you have the right to:

- Receive notice of the use and disclosure of your health/medical record, including a paper copy of the notice if requested,
- Request restrictions on use and disclosure of your health information or request we send your confidential communications by alternative means,
- Inspect and obtain a copy of your record,
- Request your health record be amended,
- Ensure the accuracy of your PHI, and
- Request an accounting of certain uses and disclosures of your PHI.

Our Responsibilities.
GPH is required to:

- Maintain the privacy of your health information, including psychotherapy and SUD counseling notes, unless you either consent or an exception to disclosure applies.
- Provide you with notice as to GPH's legal duties and privacy practices with respect to health information we collect and maintain about you.
- Abide by the terms of our most current Notice.
- Notify you if GPH is unable to abide by a requested restriction.
- Accommodate reasonable requests regarding alternative means of communicating about your PHI.
- Should GPH engage in fundraising, give you the opportunity to elect not to receive fundraising communications from GPH.
- Provide you with a single consent form allowing GPH to use and disclose your PHI for treatment, payment, and health care operations purposes.

GPH reserves the right to change and revise its privacy practices to remain in compliance with Federal and State Laws. In the event of a material change, a revised Notice shall be made available or distributed to the extent required by law.

Disclosures Permitted Without Consent.
GPH is permitted to use and disclose your health information without your consent:

- For Treatment related purposes,
- For Payment Related Purposes,
- For Health Care Operations, and
- When required by state or federal law.
- When Allowed by Law, in communications with Business Associates; for appointment reminders; to government health care authorities, including state medical officers, the Food and Drug Administration, organ procurement organizations, efforts by authorities for public health activities and protection, including disclosures related to child or adult protective services; medical emergencies; organ or tissue donation; research purposes with de-identified data; medical examiner; services to comply with laws regarding workers compensation; for certain allowed, specialized government functions, including military operations or disaster relief efforts; to government law enforcement authorities in response to a court order, or in other legal situations such as to report a crime or respond to certain valid subpoenas.

Disclosures Permitted with an Opportunity to Opt-Out. GPH may communicate with you, after giving you a chance to object or opt-out, with respect to: disclosures to family members and caregivers if relevant to that person's involvement in your care or payment for your care; solicitations regarding health-related benefits or products; for fund-raising operations; for GPH marketing efforts.

Organized Health Care Arrangement.
GPH is a member of Community Care Partnership of Maine ("CCPM"), an "Organized Health Care Arrangement" focused on improving the health of the communities it serves. The members of CCPM, in collaboration with insurance companies, use population health analytics, utilization review, quality assessment and improvement activities, and other evidence-based strategies to improve your healthcare. Members are mutually accountable for the health of all patients served by CCPM. The entities that that make up this Organized Health Care Arrangement include the following community health centers and hospitals: Cary Medical Center, Bucksport Regional Medical Center, Clinical Community Services, Eastport Health Care, Fish River Rural Health, Harrington Family Health Center, Health Access Network, HealthReach Community Health Centers, Islands Community Medical Services, Mount Desert Island Hospital, Katahdin Valley Health Center, Millinocket Regional Hospital, York County Community Action Corporation, Pines Health Services, Penobscot Valley Hospital, Pines Health Services, Regional Medical Center at Lubec, Sacopee Valley Health Center, GPH, Sebasticook Family Doctors, St. Joseph Hospital, and St. Croix Regional Family Health Center. CCPM's Organized Health Care Arrangement permits these separate covered entities, including GPH, to share PHI with each other as necessary to carry out permissible treatment, payment or health care operations relating to the work of the Organized Health Care Arrangement, unless otherwise limited by law, rule or regulation. The list of entities may be updated to apply to new entities in the future. You can access the most current list at www.ccpmmaine.org/members or call 207-992-9200.

For More Information, to Request Information or to Report a Problem
If you believe your privacy rights regarding confidential health information of any kind, including SUD treatment information have been violated by GPH, you may contact the GPH Privacy Officer, 180 Park Ave, Portland, ME 04102. (207) 874-2141); ***www.greaterportlandhealth.org***. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201 See the Office for Civil Rights website, www.hhs.gov/ocr/hipaa/ for more information.

You will not be penalized by GPH in any way for submitting a complaint.

Effective: January 2, 2026

https://www.federalregister.gov/documents/2024/02/16/2024-02544/confidentiality-of-substance-use-disorder-sud-patient-records

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 mental health, including HIV/AIDS, and dental services, to the entire community. GPH uses an electronic health record (EHR) that keeps 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 physical, mental health, substance use and/or dental records.

1. **General Consent to Treatment:** I authorize GPH providers to conduct examinations, diagnostic tests and procedures to assess my health 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 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 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, and information about possible results of choosing not to undergo recommended treatment.
2. **Right to Refuse 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 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 that GPH may share my health information, including information related to HIV/AIDS, substance use disorder treatment (as permitted or required by law), and mental health care, with my insurance carrier(s) for payment and benefit verification purposes.
4. **Notice of Privacy Practices (NPP):** I understand GPH must keep my health information confidential, but legally may use it to treat me, get paid for services provided to me, coordinate my care, or for GPH's necessary internal operations.
5. **Release of Health Care Information:** I understand that, subject to certain conditions, I may request limits on how my information is shared, ask to get communications at a specific address or phone number, and review or get copies of my protected health information with a written request. I have other rights regarding my health information as noted in the NPP.
6. **Insurance**: If I have active insurance coverage, I will 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 PCP listed is not correct.
7. **HealthInfoNet (HIN) and Maine Immunization Information System (ImmPact):** GPH participates in both systems. HIN is a secure, electronic platform where Maine health care providers share patient information to allow more informed treatment decisions. ImmPact is a secure, state-managed central repository for immunization records. Maine providers must record vaccinations therein. These are opt-out programs; if you want to learn more or opt-out, ask a care team member.
8. **Laboratory Results:** GPH contracts with NorDx Laboratories for certain laboratory services. When testing is handled by NorDx, results are available within MaineHealth's EHR. Both GPH and MaineHealth providers can access your lab results to support your care, help make informed decisions, and coordinate treatment.
9. **Assistive Technology**: GPH uses a variety of advanced computer tools, including Artificial Intelligence (AI), to support providers and care teams. These technologies do not replace your healthcare provider. We do not rely on AI systems to make decisions about your care. A licensed clinician who knows you and your medical history will make final assessments and recommendations about your diagnosis and treatment.
10. **Rules for Proper Behavior:** GPH must be a safe and respectful environment for everyone. Unsafe, abusive, or threatening behavior is unacceptable and may result in creating collaborative care agreements and possible termination from the practice.
11. **Grievance Rights**: I am aware of my grievance rights outlined in GPH's Grievance Handling Policy.
12. **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 a care team member before signing this form.

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

ccg5/2026