DEAR PARENTS/GUARDIANS,

Community Health Center, Inc. (CHC) is pleased to offer school-based health services in your child's school during the school day.

All children enrolled in the school based health services program are eligible to receive services regardless of insurance status. For children insured by HUSKY or Medicaid, the services are 100% covered (no charge). CHC accepts most insurance plans. Coverage and costs for these plans depends upon your insurance coverage.

All parts of this registration/enrollment form must be completed, signed and returned to your school before your child can receive services.

For Dental Services Only:
Mobile Dental Services are provided at many schools and community sites. Each patient will receive a cleaning and exam, as well as fluoride treatment, sealants and dental x-rays if needed. Proper brushing and flossing techniques will be reviewed. For patients with NO dental insurance, the cost for the services will be $30.00. Sealants are an additional $25.00 fee for patients with NO dental insurance. All of the services provided are 100% covered (no charge) for patients insured by HUSKY or Medicaid. These services will be provided every six months as scheduling permits. If you have no insurance, please ask staff about HUSKY insurance.

PLEASE DETACH AND SAVE

Student/Patient Information

LAST NAME	FIRST NAME	MI

STREET ADDRESS	CITY	ST	ZIP

SCHOOL	TEACHER	GRADE

ETHNICITY	RACE	SEX	DATE OF BIRTH	SOCIAL SECURITY #
☐ Hispanic ☐ Non-Hispanic	☐ Unknown ☐ Black ☐ American Indian ☐ Pacific Island ☐ Asian ☐ White ☐ Alaskan Native	☐ M ☐ F		

PHONE	OTHER PHONE	EMAIL ADDRESS

NAME OF RESPONSIBLE PARTY	RELATIONSHIP	DOB	PHONE

STREET ADDRESS	CITY	ST	ZIP

EMERGENCY CONTACT – NAME	EMERGENCY CONTACT – PHONE

Billing Information

STUDENT/PATIENT'S PRIMARY INSURANCE	INSURANCE/MEDICAID ID#	GROUP #	INSURANCE CO. PHONE

NAME OF POLICY HOLDER	POLICY HOLDER'S SSN	POLICY HOLDER'S DOB	POLICY HOLDER'S EMPLOYER

STUDENT/PATIENT'S SECONDARY INSURANCE	INSURANCE/MEDICAID ID#	GROUP #	INSURANCE COMPANY PHONE

NAME OF POLICY HOLDER	POLICY HOLDER'S SSN	POLICY HOLDER'S DOB	POLICY HOLDER'S EMPLOYER

Please check Y or N after each statement and sign at the bottom.	Y	N
I give permission for myself/my child to be treated and receive services by the school based health/mobile dental staff (Community Health Center, Inc. (CHC)). A brief health history will be conducted during initial visit with medical provider.		
Services may include Medical, Behavioral Health, and/or Dental unless otherwise noted.		
I certify that the health information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student/patient's health.		
I agree that messages can be left for me on the telephone number provided in the Student/Patient Information section of this form.		
I agree to ensure that myself/my child receives any follow-up treatment outlined by the dental hygienist or dentist.		
I have received a copy of CHC's Rights and Responsibilities Policy.		
Release of Information and Payment Authorization: I authorize the release of any medical or other information necessary to process my claim. I also authorize payment of medical benefits to Community Health Center, Inc. for service provided.		
Consent and Acknowledgement of Privacy Practices: I consent to the use or disclosure of my protected health information by Community Health Center, Inc. (CHC) to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by CHC may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how CHC will use and disclose my information can be found in CHC's Notice of Privacy Practices. I understand that this consent is effective for as long as CHC maintains my protected health information.		
Authorization for Exchange of Health & Education Information: I hereby authorize Community Health Center (CHC) to exchange health and education records with my child's school district for the purpose of providing care and treatment to my child, if applicable.		
This authorization is valid until I revoke this authorization or my child is no longer enrolled in their current school district. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records if received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my or my child's ability to obtain health care. I agree that a copy of this authorization is as valid as the original.		
By signing below, I understand and acknowledge the following: 1) I have read and understand this consent; and, 2) I have received CHC's Notice of Privacy Practices currently in effect.		

PARENT OR LEGAL GUARDIAN SIGNATURE	STUDENT SIGNATURE IF OVER 18
X	X

PRINT NAME OF INDIVIDUAL OR PARENT OR LEGAL GUARDIAN	DATE

Student/Patient & Family Medical History

STUDENT/PATIENT NAME	CHART NUMBER

Student/Patient Health Information

Is the student/patient allergic to or has had a reaction to:	Y	N
Any foods		
Any medicines (Penicillin or other anti-biotic)		
Local Anesthetics		
Latex		

Please explain any allergies:

Is the student/patient taking any medication now? If yes, please list:		
Has the student/patient had any serious injuries or sports-related injuries?		
Has the student/patient ever been hospitalized overnight?		
Has the student/patient had any surgery in the past?		
Does the student/patient have any health problems?		
Has there been any change in the student/patient's health during the past year?		
DENTAL PATIENT QUESTIONS ONLY:		
Are any of the student/patient's teeth causing him/her pain?		
Does the student/patient have any heart problems, such as heart murmur or congenital heart defects?		
Does the student/patient smoke or use chewing tobacco?		
Do the student/patient's gums bleed while brushing or flossing?		
Has child had dental cleaning in the last six months?		
Is premedication needed before dental treatment?		
FEMALE DENTAL PATIENTS ONLY:		
Is the student/patient pregnant or possibly pregnant?		
Is the student/patient nursing?		

Please explain any "Yes" answers:

Is there anything else that you think our staff should know before treating the student/patient?

Have any of the student/patient's blood relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems?

CONDITION	Y	N	CONDITION	Y	N
Allergies/asthma			Kidney disease		
Arthritis			Lung disease/tuberculosis		
Birth defects			Alcoholism/drug abuse		
Blood disorders			Mental retardation		
Sickle cell anemia			Obesity		
Diabetes			Seizures/epilepsy		
High blood pressure			Smoking		
High cholesterol			Anxiety/depression		
Endocrine/ gland disease			Cancer – type:		
Heart attack or stroke ☐ before age 55 ☐ after age 55					

Student/Patient Medical & Dental Information

PHYSICIAN'S NAME	PHYSICIAN'S PHONE
NAME OF LAST DENTIST	**DENTIST'S PHONE**
DATE OF LAST PHYSICAL EXAM	**DATE OF LAST DENTAL CLEANING**
PHARMACY	**PHARMACY PHONE**
NAME OF DENTAL INSURANCE	

Has the student/patient had any of the following illnesses or problems?

CONDITION	Y	N	CONDITION	Y	N
Anemia or blood disorders			Mononucleosis		
Asthma			Pneumonia		
Bladder or kidney infections			Rheumatic fever or heart disease		
Cancer			Scoliosis		
Chicken Pox			Seizures		
Diabetes			Severe acne		
Endocrine/gland disease			Tuberculosis		
Hepatitis			Thyroid disease		
Eating issues			Ulcer/digestive problems		
Sleep issues			Headaches/migraines		

Other concerns:

Student/Patient Behavioral Health Information

	Y	N
Has the student/patient ever received counseling or behavioral health services?		

If yes, please note –
Provider name/agency:

Dates of service:

Has the student/patient experienced any of the following behavioral health issues:

ISSUE	Y	N	ISSUE	Y	N
Family changes			Anger issues		
School issues			Attentional difficulties		
Social/ peer stresses			Sadness and/or mood swings		
Anxiety			Truancy/school avoidance		
Learning Disabilities			Recent loss		

Other behavioral health concerns:

OFFICE USE ONLY	
PROVIDER SIGNATURE	DATE

School Based Health Services

Community Health Center, Inc.

Contact Information: