GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

Dental Program Enrollment Form
2019-2020

Child's name ______________________________ Date of Birth _____ /_____/______ Gender M F T
(Same as on MaineCare card, if applicable)

Address ______________________________ Zip Code ____________________

Parent daytime phone ____________________ Msg OK yes/no Other phone ____________________ Msg OK yes/no

Student's cell (for appointment reminders) ______________ School name ________________ Teacher/Grade __________

MaineCare ID Number (ends in A) ______________________________
Private Dental Insurance: Company Name__________________ Policy ID # __________
Group # ______________________ Claim Address __________________
Policy holder's name__________________ Policy holder's date of birth __________

Uninsured ______

If you are uninsured, one of our financial assistance counselors will contact you to discuss insurance and our sliding fee scale options.

Has your child ever had any of the following? Please √ all that apply.

__ ADD/ADHD	__ Cancer/Tumors	__ Heart Disease	__ Psychiatric care
__ AIDS/HIV	__ Cerebral Palsy	__ Hepatitis	__ STI
__ Asthma	__ Cleft Lip/Palate	__ Herpes	__ Speech/hearing problems
__ Autism/Asperger's	__ Congenital Heart Disease	__ High Blood Pressure	__ Stomach/GI problems
__ Birth Defects	__ Diabetes Type	__ Kidney Disorder	__ Tuberculosis
__ Blood Disorder	__ Epilepsy/Seizures	__ Liver disorder	__ Other

Does your child have any allergies? Explain ____

List any medications your child takes ____

Does your child have tooth pain? YES NO Has your child seen a dentist in the last year? YES NO If yes, where?_____________

Language spoken at home ____________________________

Child's Race: ____ Asian ______ Black, African, African American ______ Multiracial _____ Native Hawaiian
____ Other Pacific Islander ______ South/Central/North American Indian, Alaska Native ______ White

Child's Ethnicity: ______ Hispanic/Latino ______ Not Hispanic/Latino

Total number of family members living in the household: ____________ Total Annual Household Income: ________________

Consent to Use Greater Portland Health's Children's Oral Health Program & Authorization for Release of Information

I give permission for my child, ______________________________, to use Greater Portland Health's Children's Oral Health Program, which may include diagnostic procedures and treatment, including the use of x-ray imaging and application of local anesthetic for treatment. I understand that my signature indicates that I have received and read Greater Portland Health's Privacy Notice.

- I hereby authorize Greater Portland Health's Children's Oral Health Program staff to access my child's school health record and authorize Greater Portland Health's Children's Oral Health Program staff and the school nurse or school social worker to share pertinent health information and records when it is deemed appropriate for treatment purposes.
- I hereby authorize my child's primary care provider, dentist, and mental health professional to share health information and records with Greater Portland Health's Children's Oral Health Program to support care for my child, and I give permission to Greater Portland Health's Children's Oral Health Program to share health information and records with my child's primary care provider, dentist, and mental health professional as appropriate to facilitate treatment services and the continuity and coordination of care.
- I hereby authorize personnel from any third-party agencies which contracts for the provision of health or behavioral services for my child to share health information and records with Greater Portland Health's Children's Oral Health Program to support care for my child.
- I hereby authorize Greater Portland Health's Children's Oral Health Program to release dental information and records regarding treatment to third-party payers or others of the purpose of receiving payment for services.

Authorization: This authorization is valid for the duration of time that the student is enrolled with the Portland School System or until they transfer to another school (i.e. from elementary to middle school or middle to high school). I acknowledge that when my student transfers from elementary to middle school or middle to high school, I must re-enroll them in the oral health program if I would like for them to continue receiving services at Greater Portland Health's Children's Oral Health Program. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that dental records, if received by the school district, may not be protected by the HIPAA Act, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I have read this form completely and agree to enroll my student in Greater Portland Children's Oral Health Program at this time.

Parent/Guardian Signature:______________________________ Date:____________________

Print Name:______________________________ Relationship____________________