GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

Dental Program Enrollment Form
2020-2021

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

Address _____ Zip Code _____

Parent daytime phone(s) _____Msg/Text OK yes/no Student's cell (for reminders) _____ Msg/Text OK yes/no

Email _____ 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, you may contact our financial assistance counselors to discuss insurance and our sliding fee scale options.
207-874-2141

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_____