Dental Program Enrollment Form
2022-2023

GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

Child's name ______________________________ Date of Birth _____ /_____/______ Gender _________
(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 (please √)

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: ________________

Head of Household Name: _______________________________ Relationship to Student: __________________________________

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

By signing this form, I am acknowledging and understand that:

- I have received and read Greater Portland Health's ("GPH") School-Based Dental Program Parent Letter, which explains what the GPH School-Based Dental Program is and what services and benefits it might provide for my child.
- The GPH's School-Based Dental Program is a separate entity from the school and from the school nurse's office. The GPH School-Based Dental Program provides dental assessments and a range of oral health care treatment in a school-based location while engaging in communications with other health care providers who may also be involved in the care of my child.
- This Consent 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 middle school to high school). When my student transfers from middle school to high school, I must re-enroll them in the School-Based Dental Program if I would like them to continue receiving services with the GPH's School-Based Dental Program.
- I am required to review and sign the Authorization Form for the Use and Disclosure of Health Care Information in connection with my child's enrollment in the GPH School-Based Dental Program.

I have read this form completely and agree to enroll my student in the GPH School-Based Dental Program at this time.

Parent/Guardian Signature:____ Date:_______________________

Print Name:____ Date of Birth ___-___-____ Relationship________________

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