SCHOOL BASED DENTAL CENTERS
ENROLLMENT FORM & INFORMATION
Kent & Queen Anne's County Schools

Dear Parent/Guardian:

As a student in Kent or Queen Anne's County Public School system, your child has access to the Choptank Community Health SCHOOL BASED DENTAL PROGRAM.

The mission of the Program is to **improve the health of students**, **increase access to primary health care** and **decrease time lost from school by providing care** within the school setting. We are a **convenient source** of **quality health care** that works in collaboration with your child's doctor and the school nurse.

Choptank Community Health recognizes the connection between health and positive academic outcomes. CCHS is pleased to partner with Kent and Queen Anne's County Public Schools and Kent and Queen Anne's County Health Departments to ensure that students are healthy and ready to learn.

Services Available in the School Based Dental Programs

As a student in the **Kent or Queen Anne's** County Public School system, your child has access to the **School Based Dental Program**. The program is a partnership between the Public Schools, County Health Departments and Choptank Community Health System (CCHS).

Services may include:

- dental screening for cavities
- dental cleaning & polishing
- fluoride application to help prevent or slow the progression of cavities (may be applied twice)
- protective sealants on molar teeth
- oral health education to better care for teeth
- dental emergency referrals to Dentists or Doctors

The School Based Dental Program does not take the place of your primary Dentist. A Dental Hygienist will screen your child to determine which services will be provided or if a referral is necessary. The Hygienist provides care in the school setting that promotes healthy teeth and gums. Your child should go to your dental office for a complete exam with x-rays as often as recommended by your Dentist.

If you have any questions about the program, please contact CCHS at (410) 479-4306, ext. 1038

Oral Health Goals

Floss Daily

Drink tap water

(containing fluoride)

Eat healthy snacks

The last thing to touch your child's teeth before bed is the toothbrush!

CHOPTANK community health

see how healthy you can be!

CHOPTANK community health
see how healthy you can be!

SCHOOL BASED DENTAL PROGRAM
2021-2022 ENROLLMENT/UPDATE FORM
DENTAL SERVICES AT SCHOOL

My child is a student at: _____ Grade: _____ Homeroom Teacher: _____

STUDENT INFORMATION

NAME: _____

ADDRESS: _____

_____

DOB: _____ AGE: _____ Male / Female

SOCIAL SECURITY #: _____

RACE: _____ HISPANIC/LATINO?: YES / NO

PREFERRED LANGUAGE: _____

DOCTOR: _____ PHONE: _____

DENTIST: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

PARENT/GUARDIAN INFORMATION

NAME: _____

RELATIONSHIP: _____

PREFERRED LANGUAGE: _____

#1 PHONE: _____

#2 PHONE: _____

Ok to TEXT? YES / NO

EMAIL: _____

Student Lives With: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

PHONE: _____ PHONE: _____

DENTAL INSURANCE

INSURANCE NAME: _____ POLICY/MEMBER ID#: _____

SUBSCRIBER NAME: _____ GROUP #: _____

SUBSCRIBER DOB: _____

CLAIMS ADDRESS: _____

No insurance? Would you like to apply for Sliding Fee? YES / NO # of people in household? _____ Income: $ _____/yr.

_____ I want to enroll my child in the School Based Dental Program

I understand that my signature gives consent for the CCHS School Based Dental Program Providers to treat my child and to communicate with my child's primary health care provider. I give CCHS permission to call my home, leave a message on a machine or with a person regarding healthcare information. I understand that my child's health information will be used for treatment, payment and health care operations. CCHS may also mail healthcare information to my home. I recognize that school directories may be used to obtain information left blank on the enrollment form. My child's immunization record may be shared between the School Nurse and the School Based Dental Program. For the purposes of care coordination and case management School Clinical Staff will have access to the SBDP health records and School Clinical Staff shall share health information with the SBDP staff, and. School Clinical Staff are required to treat the information in the SBDP health record as confidential and comply with the HIPAA Privacy Rule. Under no circumstances, do SBDP records become part of the student's school health record. I understand that services provided to my child will be billed to my insurance carrier or Medical Assistance. I may receive a bill from CCHS for copays and/or deductibles. I understand that my signature indicates that I have had the opportunity to receive and review the Choptank Community Health's Notice of Privacy Practices. If I do not have insurance, I will be billed for the full cost of services or with a sliding fee discount if applicable.

Parent/Guardian Signature: _____ Date: _____

PLEASE COMPLETE HEALTH HISTORY INFORMATION 

Office Use:	LC:	NA:	INS.	E	I	SF
	OHI	Prophy	FL2		Sealants	

Office Use:

☐ Posted ☐ Scanned

Date Entered: _____

STUDENT Name: _____ **DOB:** _____

DENTAL HEALTH HISTORY

LIST ALL MEDICATIONS YOUR CHILD TAKES ON A DAILY BASIS:

MEDICATION: _____ DOSE: _____mg DIRECTIONS: _____
MEDICATION: _____ DOSE: _____mg DIRECTIONS: _____
MEDICATION: _____ DOSE: _____mg DIRECTIONS: _____

YES / NO MY CHILD HAS MEDICATION / FOOD / ENRIVONMENTAL ALLERGIES?

IF YES, PLEASE LIST: _____

YES / NO HAS YOUR CHILD HAD ANY RECENT HOSPITALIZATIONS OR SURGERIES?

IF YES, PLEASE LIST: _____

YES / NO DOES ANYONE SMOKE IN THE HOME? YES NO DRUGS/ALCOHOL ADDICTION

YES / NO HAS YOUR CHILD COMPLAINED OF DENTAL PAIN IN THE PAST SIX MONTHS?

YES / NO HAS YOUR CHILD SEEN A DENTIST WITHIN THE PAST SIX MONTHS? Last Visit?: ____/____/_____

**If your child has a heart condition, please attach a medical clearance letter to the enrollment form.*

STUDENT HISTORY

HAS CHILD EVER HAD ANY OF THE FOLLOWING? (circle "yes" or "no")

YES	NO	ADD/ADHD
YES	NO	ANEMIA
YES	NO	ASTHMA/BREATHING
YES	NO	BLOOD DISORDER
YES	NO	CANCER
YES	NO	DEVELOP. DISABILITY
YES	NO	DIABETES
YES	NO	HEADACHES/MIGRAINE
YES	NO	HEARING/VISION
YES	NO	HEART PROBLEMS
YES	NO	HIGH BLOOD PRESSURE
YES	NO	HIV/AIDS
YES	NO	KIDNEY/BLADDER
YES	NO	LEAD POISONING
YES	NO	LIVER PROBLEMS
YES	NO	MENTAL ILLNESS
YES	NO	OBESITY
YES	NO	SEIZURES/EPILEPSY
YES	NO	SKIN PROBLEMS
YES	NO	STOMACH PROBLEMS
YES	NO	STROKE
YES	NO	THYROID PROBLEMS
YES	NO	TOOTH DECAY
YES	NO	TUBERCULOSIS

OTHER: _____

FAMILY HISTORY

HAS AN IMMEDIATE FAMILY MEMBER (parent, sibling, grandparent) EVER HAD ANY OF THE FOLLOWING? (circle "yes" or "no")

YES	NO	ADD/ADHD	Who?: _____
YES	NO	ANEMIA	Who?: _____
YES	NO	ASTHMA/BREATHING	Who?: _____
YES	NO	BLOOD DISORDER	Who?: _____
YES	NO	CANCER	Who?: _____
YES	NO	DEVELOP. DISABILITY	Who?: _____
YES	NO	DIABETES	Who?: _____
YES	NO	HEADACHES/MIGRAINE	Who?: _____
YES	NO	HEARING/VISION	Who?: _____
YES	NO	HEART PROBLEMS	Who?: _____
YES	NO	HIGH BLOOD PRESSURE	Who?: _____
YES	NO	HIV/AIDS	Who?: _____
YES	NO	KIDNEY/BLADDER	Who?: _____
YES	NO	LEAD POISONING	Who?: _____
YES	NO	LIVER PROBLEMS	Who?: _____
YES	NO	MENTAL ILLNESS	Who?: _____
YES	NO	OBESITY	Who?: _____
YES	NO	SEIZURES/EPILEPSY	Who?: _____
YES	NO	SKIN PROBLEMS	Who?: _____
YES	NO	STOMACH PROBLEMS	Who?: _____
YES	NO	STROKE	Who?: _____
YES	NO	THYROID PROBLEMS	Who?: _____
YES	NO	TOOTH DECAY	Who?: _____
YES	NO	TUBERCULOSIS	Who?: _____

OTHER: _____

Additional Information: _____

_____

PLEASE RETURN COMPLETED ENROLLMENT TO YOUR SCHOOL NURSE. THANK YOU!

Documented and reviewed by: _____