Finger Lakes
COMMUNITY HEALTH
Taking the time to care.

Dear Parent/Guardian,

In our ongoing effort to better serve the community, we are offering this unique opportunity for your child to receive dental care at their school. We understand how difficult it can be to make and keep appointments, losing time from work, or experiencing the difficulty of finding a provider that accepts Child Health Plus and Medicaid in our area. Many people have no insurance at all.

You **will not** receive a bill for dental care provided for your child during our visit to the school, but if your child has dental insurance, it is important that we know their insurance carrier and number.

For your child to be seen in this program **you must complete and sign the attached forms and return them to the school**. The forms provide us with important health information and consent needed to provide this care.

You may accompany your child to their visit if you would like, just note contact information on the last page. If your child is seen by the dental team, we will send you a report of the care given to your child during the visit. If your child requires additional treatment we will send home treatment recommendations and/or phone you.

Please return this enrollment form to your child's teacher, even if your child is not going to participate as soon as possible, we are at the school for a limited time. Thank you, we look forward to visiting your school!

Child's Name:_____School/Teacher:_____/_____Grade:___

- ☐ I DO wish for my child to participate in the program. (Please continue to complete forms.)
- ☐ I DO NOT wish for my child to participate in the program. We have a dentist. (Please sign and return)

_____ _____ _____

Signature Parent/Guardian **Print Name** **Date**

Please circle Yes or No for *each* of the following services you wish for your child to receive:

Yes	No	Examination (checking for cavities and/or gum disease) – by the Dentist
Yes	No	Free dental screening, toothbrush/floss & oral hygiene instructions
Yes	No	Teeth cleaning, toothbrush/floss & oral hygiene instruction.
Yes	No	Fluoride treatment (a coating to increase protection against cavities)
Yes	No	Fluoride treatment every 3 months & toothbrush for my child 6 years old or younger
Yes	No	X-Rays (to see if there are any cavities, required to provide fillings)
Yes	No	Sealants (a covering to protect the teeth from getting cavities)
Yes	No	Fillings (examination & x-rays required prior to fillings)

Finger Lakes Community Health
Administrative Offices · 14 Maiden Lane · PO Box 423 · Penn Yan, NY 14527
p: 315-531-9102 · **f:** 315-531-9103 · **w:** www.localcommunityhealth.com

Bath Community Health · Geneva Community Health · Newark Community Health · Ovid Community Health
Penn Yan Community Health · Port Byron Community Health · Sodus Community Health · Dundee Dental Center

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Health History

Child's Name: _____ **Child's DOB:** _ _/_ _/_ _ _ _

Has your child or has your child ever had ...	Yes	NO	Additional Information
ADHD/ADD			
Allergy to Latex			
Allergy to Medication(s)			List:
Asthma			
Blood Disorder/Anemia			What kind?
Hepatitis A, B, C, or D (circle one)			When Diagnosed?
Diabetes			When diagnosed?
Heart Trouble (including murmur, prosthesis)			
Low/High Blood Pressure (circle one)			
Pregnancy			
Seizures or Epilepsy			Date of last seizure?
Tuberculosis (TB)			
Other Allergies			List:
Other			List:
List any major surgeries (types and dates)			List:
List any reason for any overnight hospitalizations in past 3 years?			List:

	Yes	No/Unsure
Does your child have a Medical Provider (Doctor, Nurse Practitioner or Physician Assistant)? If yes, Name of Provider:		
Is your child currently being treated by his/her medical provider for any reason? If yes, explain:		
Is your child taking any medications (including vitamins and/or fluoride)? If yes, please list:		
Does your child have a dentist? If yes, Name and phone number of the Dentist:		
Has your child had a dental exam in the past 6 months?		
Has your child had a dental cleaning in the past 6 months?		
Do you have any concerns regarding your child's dental health? If yes, please explain:		
What is the source of your child's water? (please circle) Well Town/City Bottled		

_____ _ _/_ _/_ _ _ _

Doctor/Hygienist Signature **Date**

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Child's Name: _____ **Date of Birth:** _____ **Child's Sex: Male or Female**

Child's Address: _____ **City:** _____ **Zip Code:** _____

Language: ☐ English ☐ Spanish ☐ Other **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ Asian ☐ American Indian

PARENT/GUARDIAN INFORMATION and RESPONSIBLE PARTY

Mother's Name: _____ Phone Number: (H) (___) ___-_____ (C) (___) ___-_____ (W) (___) ___-_____
Email: _____

Father's Name: _____ Phone Number: (H) (___) ___-_____ (C) (___) ___-_____ (W) (___) ___-_____
Email: _____

Guardian's Name: _____ Phone Number: (H) (___) ___-_____ (C) (___) ___-_____ (W) (___) ___-_____
Email: _____

Would you like to accompany your child to their visit? No Yes The best way to reach me is: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to child: _____

Phone Numbers: (H) (___) ___-_____ (C) (___) ___-_____ (W) (___) ___-_____

INSURANCE INFORMATION ***(This information can be found on your medical or dental insurance card)***
☐ ***NO, my child doesn't have Dental Insurance*** ☐ ***YES, my child has Dental Insurance***

Dental Insurance Name: _____ Subscriber/Enrollee ID: _____

Group Number: _____ Group Name : _____

Insurance Company Street Address: _____ City: _____, State: _____ Zip: _____

Name of person who carries the insurance: _____ Date of Birth: __ __/__ __/__ __ __ __

Relationship to the patient: _____

CONSENT:
In order for us to treat your child you must sign below indicating you have read and agree to the following information.

Authorization for Treatment - I, the undersigned, the parent or legal guardian of the above named child, herby authorizes the dental staff of FLCH to provide dental care as indicated to my child in his/her school.

Financial Responsibility/Assignment of Benefit - I authorize FLCH to apply for benefits on my behalf to my child's insurance carrier and request my child's insurance company pay directly to FLCH insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify FLCH of any changes.

Release of Information consent to having my child's doctor release medical information to the FLCH dental staff, if my child's health history indicates health problems which may affect his/her dental treatment. If a dentist is noted above, I understand that any findings/treatment shall be forwarded to them. FLCH is in compliance with the Health Information Privacy Act and I may have a copy sent to me.

_____ _____ __/__/__ __ __
Parent/Guardian Signature **Print** **Date**

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Farmworker Eligibility Form

Child's Name:_____ **Child's DOB:**_ _/_ _/_ _ _ _

Please note: Spouse and children of farmworkers must answer the questions based on the farmworker. The spouse and/or child of a farmworker will be categorized by the farmworker's status (whether the spouse or child is insured or not).

Question	Yes	No
Have you or a member of your family **EVER** worked in agriculture/farming, like: preparing, irrigating or spraying the fields, nurseries, orchards; planting, picking, sorting, packing, or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay, or other agricultural products; planting trees; working with Christmas trees; picking pine needles or Spanish moss; taking care of chickens, ducks, turkeys, cows, goats, sheep, fish, clams, etc.,		

If you answered YES to this question, please continue to the next section.

Question	Yes	No
Did you or your family member have to establish a temporary home in order to work in agriculture? • Trailers or houses provided by your employer • Hotels • Apartments • Living with friends or relatives		
If yes, when did you come to this area?		

If you answered NO please continue on to the next section.

Question	Yes	No
Did you or a family member work in agriculture on a seasonal basis? Working on a seasonal basis means any of the following: • Your hours changed from week to week • Your income changed from week to week • You were laid off for part of the year and had to do other work, like in construction, housekeeping, or in restaurants		

If you answered NO please continue on to the next section.

Question	Yes	No
Have you or a member of your family stopped traveling to work in agriculture because of a disability or old age?		

I confirm that the answers given on this form are true and accurate.

Parent/Guardian Signature: _____ **Date:** _____