Hilltown Community Health Center

GATOR GRINS MOBILE DENTAL PROGRAM

12 Littleville Road , Huntington, MA 01050 413-667-3009 Ext: 239

Child's Name: _____Date of Birth:___/___/____ □ Male □ Female

Address:_____Town:_____

E-mail: _____Social security number:_____-_____-_____

School:_____Grade:_____

□ YES, I give permission for my child to participate in the Gator Grins Dental program.
Please complete the form.

□ NO, I do NOT give permission for my child to participate in the program.
Please initial box and return -- you do not need to fill out form below. ☐

1. Does your child see a doctor for regular checkups? □ Yes □ No When was your child last seen? _____

2. Does your child see a dentist for regular checkups? □ Yes □ No When was your child last seen? _____
if yes, name of the dentist:_____

3. In general, how would you describe the health of your child's teeth and mouth?
□ excellent □ very good □ good □ fair □ poor

4. Is your child taking any medication now? □ yes □ no if yes, please list :_____

5. Does your child take fluoride tablets daily?_____□ yes □ no

6. Does your child receive fluoride rinse at school?_____□ yes □ no

7. Has a dentist or physician ever told you that your child needs to take antibiotics (i.e. penicillin) before receiving dental treatment?_____□ yes □ no

8. Please check any illnesses or conditions your child has ***EVER*** had:
□ ADD/ADHD □ Diabetes □ Hepatitis □ Rheumatic Fever □ Convulsions □ Anemia
□ Epilepsy □ Seizures □Asthma □ Heart Murmur □ Allergies to Medicine
□ HIV/AIDS □ Autism □ Tuberculosis □ Kidney/Liver □ Heart Conditions

9. Does your child have any other health conditions? □ yes □ no if yes, please list:_____

10. Does your child have any allergies? □ **YES** □ **NO** if yes, please check all that apply: □ Penicillin □ Antibiotics
□ Aspirin □ Foods □ Latex □ Resins □ Others: _____

11. Does your child have Dental Insurance?_____ □ yes □ no
if no, would you like help getting Health or Dental insurance for your child?_____ □ yes □ no
if no, do you have Health Safety Net?_____ □ yes □ no

12. Mass Health Number: (10 digit number):_____

13. Dental Ins. Company Name: _____Dental phone number:_____
- Subscriber Name (parent):_____ Subscriber Birthday:_____
- Subscriber's SS# or ID #:_____ Group or Plan #:_____

14. Medical Ins. Company Name: _____ ID #: _____

PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD

I understand that Hilltown Community Health Centers may use my health information for treatment, payment and health care operations. To read health information exchange (HIE) or patients' rights, HIPAA information it is located on the Hilltown Community Health Centers website at www.hchcweb.org, it is 7 pages long, if you would like a copy sent to you please call 413-667-3009 Ext 239. I am aware teachers and staff may have access to our schedule to coordinate with school schedules. I have read and understand the dental plan and I consent to have my child participate in the dental program which may include dental exams, cleanings, x-rays, fluoride, sealants or fillings. I understand that fluoride varnish may be applied at the Gateway SBHC in collaboration with Gator Grins if the dental program is unavailable at the time it's due. If I have dental insurance, I authorize my insurance carrier to be billed for any services provided.

X_____ Date: ___/___ /___ Relationship to child: _____
Parent/guardian signature

X_____ _____ _____
Print name Daytime phone Home phone