Hilltown Community Health Center
73 Russell Road, Huntington, MA 01050 413-667-3009 ext. 239

NEW HINGHAM SCHOOL- BASED DENTAL OUTREACH PROGRAM

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 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 having 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 and if you need a copy sent to you please call 413-667-3009 ext. 239. I am aware teachers and staff may have access to our schedule in order to coordinate daily with the school system. I have read and understand the dental plan and I consent to have my child participate in the program which may include dental exams, cleanings, x-rays, fluoride, sealants or fillings. If I have dental insurance, I authorize my insurance carrier to be billed for any services provide.

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

_____ _____ _____
print name day phone home phone

PLEASE TURN OVER AND SIGN PRIVACY FORM ON BACK OF SHEET