Hilltown Community Health Center

R.H. CONWELL SCHOOL-BASED DENTAL PROGRAM

Admin Offices: 12 Littleville Road , Huntington, MA 01050 413-667-0142

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 School Based 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 about health information exchange (HIE) or patients' rights, HIPAA information it is located on the Hilltown Community Health Centers website at www.hchcweb.org. As it is 7 pages long, I understand that if I would like a copy sent to me I will 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. 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

PLEASE TURN OVER AND SIGN PRIVACY FORM ON BACK OF SHEET 2016