Community Health Center, Inc.
Mobile Dental Program is at your school!

In-School Services Provided

**Oral Health Services include:**
- Screenings
- Exams
- Cleanings
- X-Rays
- Sealants
- Oral Health Education
- Restorative Care

The following fees/charges apply to Community Health Center, Inc.’s Mobile Dental Program:

- For patients enrolled in HUSKY/Medicaid, services are 100% covered with no additional fees or charges.
- For patients with private dental insurance, services are billed to insurance. Patient/Family is responsible for any deductible and/or co-pay.
- For patients with no dental insurance the following fees apply:
  - $30 for Dental Hygiene visit (cleaning, x-rays, fluoride)
  - $18 per visit for exam by the Dentist
  - $25 per visit for sealants

Please keep this sheet for your records.

**Questions or concerns? Call 860-347-6971 ext: 3796.**
You can also enroll online: [http://www.sbhc1.com](http://www.sbhc1.com)
I give my child/self permission to obtain ON-SITE MOBILE DENTAL SERVICES.

For patients enrolled in HUSKY/Medicaid, services are 100% covered with no additional fees or charges. For patients with private dental insurance, services are billed to insurance. Parent/Family is only responsible for any deductible and/or co-pay. For patients with no health insurance the following fees apply:

- $30 for Dental Hygiene visit (cleaning, x-rays, fluoride); $25 per visit for sealants; $18 per visit for exam by the Dentist

RISKS: Although infrequent, some risks and complications are known to be associated with dental procedures. The most common include biting and injuring tongue or lip following the administration of local anesthesia and soreness around the area being treated. Additional risks include infection and swelling.

I certify that the health information provided is accurate to the best of my knowledge and understand that incorrect information can be dangerous to the student/patient’s health. I will notify CHC if any changes to medical information.

I have received a copy of CHC’s Rights and Responsibilities Policy.

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION:
I authorize the release of any dental or other information necessary to process my claim. I also authorize payment of health benefits to Community Health Center, Inc. for services provided.

CONSENT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES:
I consent to the use or disclosure of my protected health information by CHC to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information use or disclosed to CHC may include HIV/AIDS related information, psychiatric/mental health information, drug/alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how CHC will use and disclose my information can be found in CHC’s Notice of Privacy Practices. I understand my consent is effective for as long as CHC maintains my protected health information.

AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION:
I hereby authorize Community Health Center, Inc. (CHC) to exchange health and education records with my child’s school district for the purpose of providing care and treatment to my child, if applicable.

PATIENT INFORMATION * Required information.

Full Legal Name: ___________________________ Date of Birth: ____________
Street Address/Apt #: _________________________ City: ______________ ZIP: ___________
Sex: □ Male □ Female Social Security Number: ________________
Race (check box): □ Unknown □ American Indian □ Pacific Island □ Alaskan Native □ Black □ Asian □ White □ Other
Patient’s Primary Language: ________________ Does the patient qualify for free/reduced lunch?: □ Yes □ No
School Patient Attends: ______________________ Grade: ______________
Primary Care Provider’s Name: ____________________ Phone Number: _____________
Dentist’s Name: _____________________________ Phone Number: _____________

INSURANCE INFORMATION

* Medical Insurance: ____________ * Medicaid ID #: ____________
* Private Ins. ID/Policy #: ____________ * Group Number: ____________
* Insurance Address: ___________________________ * Insurance Phone Number: ____________ (info on back of card)
* Policy Holder Name: ___________________________ * Policy Holder DOB: ____________
* Dental Insurance: ___________________________ * Private Ins. ID/Policy #: ____________
* Group Number: ____________
* Insurance Address: ___________________________ * Insurance Phone Number: ____________ (info on back of card)
* Policy Holder Name: ___________________________ * Policy Holder DOB: ____________

PARENT/GUARDIAN INFORMATION

Name: ___________________________ Relationship to Patient: ____________ DOB: ____________
* Street Address/Apt #: (if different from above): ___________________________ City: ____________ ZIP: ____________
I agree that messages can be left for me on: □ Home Phone □ Cell Phone □ Work Phone
Home Phone: ___________________________ Cell Phone: ___________________________ Work Phone: ___________________________
Student’s Cell Phone: ___________________________ Student’s Email Address: ___________________________ Email Address of Parent/Guardian: ___________________________

EMERGENCY CONTACT (if different than Parent/Guardian)

Name: ___________________________ Relationship to Patient: ____________ Phone Number: ____________

* Signature of Parent/Legal Guardian or Student if over 18 years old:

* Print Name: ___________________________ Date: ___________________________

By signing above, I understand and acknowledge that I have read and understand this consent and I have received CHC’s Notice of Privacy Practices currently in effect. I also understand that this authorization is valid until I revoke this authorization. I understand I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records if received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by Family Education Rights and Privacy Act.
### MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Yes</th>
<th>No</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have any medical conditions?</td>
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<tr>
<td>Does the patient take any medications? (including inhalers)</td>
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<tr>
<td>Has the patient had any serious injuries?</td>
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<tr>
<td>Does the patient have a birth or heart defect or have history of a heart problem or surgery?</td>
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<tr>
<td>Has the patient ever been hospitalized overnight?</td>
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<tr>
<td>Has the patient had any surgery in the past?</td>
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<tr>
<td>Has the patient had any shunts placed or has an indwelling catheter?</td>
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<tr>
<td>Is/was the patient a teen parent?</td>
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<tr>
<td>Is the patient pregnant or possibly pregnant?</td>
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<tr>
<td>Is the patient currently nursing?</td>
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<tr>
<td>Is premedication with antibiotics needed prior to dental procedures?</td>
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<tr>
<td>Does the patient smoke or chew tobacco?</td>
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</tbody>
</table>

### Does the patient have or had any of these PROBLEMS?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia/blood disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Autism</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bladder or kidney infections</td>
<td></td>
<td></td>
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<tr>
<td>Cancer/leukemia</td>
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<td></td>
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<tr>
<td>Chicken pox</td>
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<td></td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Eating issues</td>
<td></td>
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<td></td>
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<tr>
<td>Endocrine/gland disease/autoimmune disease</td>
<td></td>
<td></td>
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<tr>
<td>Headaches/migraines</td>
<td></td>
<td></td>
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<tr>
<td>Hepatitis or liver problems</td>
<td></td>
<td></td>
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<tr>
<td>Learning/developmental issues</td>
<td></td>
<td></td>
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<tr>
<td>Mononucleosis</td>
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<tr>
<td>Overweight/obesity</td>
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<tr>
<td>Pneumonia</td>
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<tr>
<td>Rheumatic fever, heart disease, murmur</td>
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<td></td>
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<tr>
<td>Seizures</td>
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<td></td>
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<tr>
<td>Thyroid disease</td>
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<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
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<td></td>
<td></td>
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<tr>
<td>Ulcer/digestive problem</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Any mental health issues</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Any birth or congenital defects (spina bifida, brain, heart, lung, etc.)?</td>
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<tr>
<td>Any problems with teeth</td>
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<tr>
<td>Any teeth causing pain</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Any bleeding when brushing or flossing?</td>
<td></td>
<td></td>
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<tr>
<td>Had a dental cleaning within the last 6 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ALLERGIES

<table>
<thead>
<tr>
<th>Allergy Description</th>
<th>Yes</th>
<th>No</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any foods (including lactose intolerance)</td>
<td></td>
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<tr>
<td>Any medications (including over the counter or antibiotics; penicillin or amoxicillin)</td>
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<tr>
<td>Local anesthetics (including lidocaine) or latex</td>
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<tr>
<td>Does the patient have an Epi-Pen at school?</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

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**Student/Patient Medical History** *(For Dental, this medical history will need to be updated every four years.)*

**Patient Name:** ___________________________________________  **Date of Birth:** ____________________________

**Medical History:**

- Does the patient have any medical conditions? [ ] YES [ ] NO  **Explain:** __________
- Does the patient take any medications? (including inhalers) [ ] YES [ ] NO  **List all medications:** __________
- Has the patient had any serious injuries? [ ] YES [ ] NO  **Explain:** __________
- Does the patient have a birth or heart defect or have history of a heart problem or surgery? [ ] YES [ ] NO  **Explain:** __________
- Has the patient ever been hospitalized overnight? [ ] YES [ ] NO  **Explain:** __________
- Has the patient had any surgery in the past? [ ] YES [ ] NO  **Explain:** __________
- Has the patient had any shunts placed or has an indwelling catheter? [ ] YES [ ] NO  **Explain:** __________
- Is/was the patient a teen parent? [ ] YES [ ] NO
- Is the patient pregnant or possibly pregnant? [ ] YES [ ] NO  **Due date:** __________
- Is the patient currently nursing? [ ] YES [ ] NO
- Is premedication with antibiotics needed prior to dental procedures? [ ] YES [ ] NO  **Explain:** __________
- Does the patient smoke or chew tobacco? [ ] YES [ ] NO

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**Allergies:**

- Anemia/blood disorders [ ] YES [ ] NO
- Asthma [ ] YES [ ] NO
- Autism [ ] YES [ ] NO
- Bladder or kidney infections [ ] YES [ ] NO
- Cancer/leukemia [ ] YES [ ] NO
- Chickenpox [ ] YES [ ] NO
- Diabetes [ ] YES [ ] NO
- Eating issues [ ] YES [ ] NO
- Endocrine/gland disease/autoimmune disease [ ] YES [ ] NO
- Headaches/migraines [ ] YES [ ] NO
- Hepatitis or liver problems [ ] YES [ ] NO
- Learning/developmental issues [ ] YES [ ] NO
- Mononucleosis [ ] YES [ ] NO
- Overweight/obesity [ ] YES [ ] NO
- Pneumonia [ ] YES [ ] NO
- Rheumatic fever, heart disease, murmur [ ] YES [ ] NO
- Seizures [ ] YES [ ] NO
- Thyroid disease [ ] YES [ ] NO
- Tuberculosis [ ] YES [ ] NO
- Ulcer/digestive problem [ ] YES [ ] NO
- Any mental health issues? [ ] YES [ ] NO
- Any birth or congenital defects (spina bifida, brain, heart, lung, etc.)? [ ] YES [ ] NO
- Any problems with teeth? [ ] YES [ ] NO
- Any teeth causing pain? [ ] YES [ ] NO
- Any bleeding when brushing or flossing? [ ] YES [ ] NO
- Had a dental cleaning within the last 6 months? [ ] YES [ ] NO

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**Comment:** __________

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Mobile Dental Services are a division of Community Health Center, Inc.  [www.chc1.com](http://www.chc1.com) | Facebook/CHCInc | Twitter(@CHCConnecticut)
II. How CHC May Use or Disclose Your Health Information

A. For Treatment, Payment, and Health Care Operations. CHC may use and disclose your health information to provide you with treatment and services and to coordinate your continuing care. Your health information may be used by doctors, counselors, dentists, and nurses, as well as by lab technicians, dietitians, specialists or others involved in your care, both within and outside CHC. For example, a pharmacist will need certain information to fill a prescription ordered by your doctor.

B. For Payment. CHC may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

C. For Health Care Operations. CHC may use and disclose health information about you for operational purposes, for example, your health information may be used by members of the medical staff, the staff of community health centers, and others to evaluate the performance of our staff; Assess the quality of care and outcomes in your case and similar cases; Learn how to improve our facilities and services; and Determine how to continually improve the quality and effectiveness of the health care we provide.

B. Other Uses and Disclosures We May Make Without Your Written Authorization

1. Appointments. CHC may use your information to call, mail letters or postcards, or send to your patient portal to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual. CHC may use or disclose your information in certain electronic communications, in writing, that CHC believes will enhance your health or safety, or will help you in organizing your health care. For example, CHC may contact you by phone, fax, text or email if you have given consent. CHC will not call, mail letters or postcards, or send to your patient portal to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

2. Required by Law. CHC may use and disclose information about you as required by law.

3. Persons Involved in Your Care or Payment for Your Care. We may disclose health information about you to a family member, close personal friend or other persons you identify in your Privacy to Share Health Information form. These disclosures are limited to the information relevant to the person’s involvement in your care or in arranging payment for your care and only to those individuals you have specified specifically that you may wish to communicate with.

4. Public Health Activities. We may disclose your health information for public health activities. These activities generally include: 1.) to prevent and control disease, injury or disability; 2.) to report child or elder abuse and neglect; 3.) to report problems with medical- tions; and 4.) to report immunizations to the CIRTS registry.

5. Reporting Victims of Abuse, Neglect or Domestic Violence. If we believe that you have been a victim of child or elder abuse or neglect, we may disclose your health information to the appropriate government authority.

6. Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. A health oversight agency is a state or federal agency that oversees the health care system. Some of the activities include: 1.) to prevent and control disease, injury or disability; 2.) to report problems with medical- tions; and 4.) to report immunizations to the CIRTS registry.

7. Judicial and Administrative Proceedings. We may disclose your health information in response to a court or administrative order. We also may disclose information in re- sponse to a subpoena, discovery request, or other lawful process.

8. Law Enforcement. We may disclose your health information for certain law enforce- ment purposes, including, for example, to file reports of criminal conduct; to report酒!” to the federal, state, or local law enforcement authorities; or to assist in the investigation of a crime. We may disclose your health information as authorized in response to a judicial or administrative order or in response to any other lawful process.

9. Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may disclose your health information to a coroner, medical examiner, funeral direc- tor and, if you are an organ donor, to an organ procurement organization to help them carry out their duties.

10. To Avert a Serious Threat to Health or Safety. When necessary to prevent a serious threat to your health or safety, or the health or safety of the public or another person, we may use or disclose your health information to someone able to help lessen or prevent the threat to health or safety.

11. Military and Veterans. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities.

12. National Security and Intelligence Activities; Protective Services for the President and Others. We may disclose health information to law enforcement officials conducting national security and intelligence activities or as needed to provide protection to the President of the United States, certain other persons or foreign heads of states or of conduct certain special investigations.

13. Inmates/Law Enforcement Custody. If you are an inmate of a correctional institu- tion or under the custody of a law enforcement official, we may disclose your health information to the institution or official for certain purposes including your own health and safety as well as that of others.

14. Workers’ Compensation. We may use or disclose your health information to comply with laws relating to workers’ compensation or similar programs.

15. Disaster Relief. We may disclose health information about you to an organization assisting in a disaster relief effort.

16. Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.
17. Business Associates. We may disclose your health information to our business associates under a Business Associate Agreement.

18. Research. CHC may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal established protocols and has approved the research to ensure the privacy of your health information.

C. Your Written Authorization is Required for All Other Uses or Disclosures of Your Health Information

1. We will obtain your written authorization (an “Authorization”) prior to making any use or disclosure other than those described above. Most uses and disclosures of behavioral health notes, uses and disclosures of your protected health information that are made for marketing purposes or disclosures that constitute a sale of protected health information require your written authorization.

2. A written Authorization is required to inform you of a specific use or disclosure (other than those described above) that we plan to make of your health information. The Authorization describes the particular health information we will use or disclose, the purpose of the use or disclosure. Where applicable, the written Authorization will also specify the name of the person to whom we are disclosing the information. The Authorization will also contain an expiration date.

3. You may revoke a written Authorization previously given by you at any time but you must do so in writing. If you revoke your Authorization, we will no longer use or disclose your health information for those purposes specified in the Authorization except where we have already taken action in reliance on your Authorization.

D. Your Rights Regarding Your Health Information

1. Right to Request Restrictions. You have the right to request that we restrict how we use or disclose your health information for treatment, payment or health care operations. However, we are not required to agree to the restriction except under limited circumstances. For example, we must agree to your request to restrict disclosures about you to your health plan for purposes of payment or healthcare operations that are not required by law if the information pertains solely to a healthcare item or service for which you have paid us in full out of pocket. If we do agree to a restriction, we will honor that restriction except in the event of an emergency.

2. Right to Request Confidential Communications. You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number. We will accommodate your reasonable request.

3. Right of Access to Personal Health Information. You have the right to inspect and, upon written request, obtain a copy of your health information.

4. Right to Request Amendment. You have the right to request that we amend your medical information. Your request must be made in writing and must state the reason(s) for the requested amendment. We may deny your request for amendment under certain circumstances. If we deny your request for amendment, we will give you a written denial notice, including the reasons for the denial. You have the right to submit a written statement disagreeing with the denial which will be included in your medical record.

5. Right to an Accounting of Disclosures. You have the right to request an “accounting” of certain disclosures of your health information. You must submit your request in writing and you must state the time period for which you would like the accounting of disclosure. The accounting will include the disclosure date; the name of the person or entity that received the information and address, if known; a brief description of the information disclosed; and a brief statement of the purpose of the disclosure. The first accounting provided accounting within a 12-month period will be free; for further requests, we may charge you our costs for completing the accounting.

6. Notification of Breaches of Your Health Information. You have the right to receive written notification of any “breach” of your unsecured protected health information, as that term is defined in 45 CFR §164.402.

E. Special Regulations Regarding Disclosure of Behavioral Health and HIV-Related Information.

For disclosures concerning certain health information such as HIV-related information or records regarding behavioral health care that have been sent to us by another provider, special restrictions apply. Generally, we will disclose such information only with an Authorization, or as otherwise required by law.

F. For Information About This Notice or to Report A Concern Regarding Our Privacy Practices

1. If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the Office of Civil Rights.

2. To file a complaint with us, you should contact: Privacy Officer, Community Health Center, Inc., 575 Main Street, 2nd Floor, Middletown, Connecticut 06457, Tel: 860-347-6971 (3651) or (3535).

3. We will not retaliate against you in any way for filing a complaint against CHC.