**HealthHUB Student Dental Enrollment Form**

Our mobile Dental Hygiene facility will be visiting your school. Services provided include dental cleanings, oral evaluation, necessary x-rays, fluoride treatment, sealants, and silver diamine fluoride, which can stop cavities. Students are eligible if they have NOT had their teeth cleaned within the last 6 months. Students who have a dental home may not be eligible-you can call for more information.

Your dental insurance, including Medicaid, will be billed or you may self-pay. Please call for fees. If you do not provide ALL insurance information, you will be responsible for the entire cost of the visit.

By signing this form and enrolling my child(ren) in HealthHUB’s dental program, I consent to:

* Treatment performed by the dental hygienist is limited in scope, according to the Vermont Statutes and Rules of dental hygiene scope of practice, and that it does not​ take the place of a regular dental examination or treatment by a licensed dentist.
* The dental hygienist works collaboratively with school nurses, your child’s dentist and medical care provider with whom communication, records and x-rays may be shared and will be kept confidential. If your child does not have a dentist, a referral may be made with communication, records and x-rays shared in a confidential manner for your child’s continued care.
* Dental records for services provided by the dental hygienist will be reviewed by a VT licensed dentist in which the dental hygienist holds a general supervising agreement.
* It is my responsibility to follow up with any treatment or examination, by a DENTIST, that the dental hygienist recommends for my child.
* If my child does not have Medicaid or private dental insurance it is my responsibility to pay HealthHUB for services. I also understand that I will pay any co-pays with private insurance.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my permission for HealthHUB to share my child’s dental hygiene records with my child’s dentist, school nurse and medical provider. If my child does not have a regular dentist, a referral may be made to a dentist which will include information about the dental hygiene visit. I have reviewed the HIPAA/Privacy policy.

Signature of parent/guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any dental questions, you may contact Tammy, our dental division manager,at tammy@healthhubvt.org or leave a message at (802) 547.3884

Please check:

(   ) Yes, please enroll my child in dental hygiene care with HealthHUB.             (Includes up to 1 oral health screening, 1 cleanings within the year, fluoride and necessary x-rays)

(   ) Yes, please place preventative dental sealants on permanent molars, if needed.

(   ) Yes, please apply cavity-stopping silver diamine fluoride (SDF) on areas where the treatment will not be seen (back teeth). I have read and signed the SDF permission form.

Student’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth \_\_\_\_\_\_\_\_\_\_                  Grade/School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender (Please circle): Male / Female / Other / Prefer not to answer

Student’s Race (Please circle):  
White/Non-Hispanic   Black/Non-Hispanic   Hispanic   Asian/Pacific Islander    Native American/Alaskan Native    Unknown   Other\_\_\_\_\_\_\_\_\_\_\_\_    Prefer not to answer

If you have Vermont Medicaid, you MUST provide the ID # or you will be expected to pay for your child’s visit. We can NOT access account numbers for you.

Medicaid ID # (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private DENTAL Insurance Information:

Insurance Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins. Co. Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins. Co. Phone #\_\_\_\_\_\_\_\_\_\_

Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                          Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address if different than child’s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Information:  
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                       Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address if different than child’s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Usual Source of Medical Care

Doctor/Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty care provider (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health History

Has the student seen a health care provider (e.g. physician or nurse practitioner) in the last year? Please circle: Yes No  If yes, how many visits? \_\_\_\_\_\_ Reasons for these visits?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the student seen a dental provider in the last year? Please circle: Yes No    Reasons for these visits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental x-rays and cleaning\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the student on any medication? Yes No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the student allergic to anything? Yes No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student have any chronic medical conditions or things they are treated for on a regular basis? (for example, asthma, allergies, diabetes, mental health) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the student ever stayed overnight in the hospital or had any surgeries? Please describe.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Description of: fluoride, sealants and silver diamine fluoride.](https://www.healthvermont.gov/sites/default/files/documents/pdf/Difference%20between%20varnish%2C%20sealant%2C%20and%20SDF.pdf)