ACROSS THE SMILES

GENERATIONS FAMILY HEALTH CENTER

Our dental program can provide dental care to enrolled students.

Students enrolled will receive Exams, Cleanings, Fluoride Treatment, Sealants, X-rays and Oral Health Education.

You will be notified of all the care we provide.

Children identified with cavities or other restorative needs will be referred to see a dentist.

If you would like to enroll your student, please complete all information on this form and return to the school.
(A new form is required each year)

If you would like information about this program and the services we provide, please visit our web site at www.genhealth.org or call our office at (860) 963-7917.

Now Offering Patient Portal. Call for details.

Generations Family Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Generations does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Spanish ATENCÍON: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-808.9008.

Haitian ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-808-9008.

GENERATIONS

FAMILY HEALTH CENTER

202 Pomfret Street
Putnam, Connecticut 06260
(860) 963-7917 * genhealth.org

ACROSS THE SMILES

GENERATIONS FAMILY HEALTH CENTER

PATIENT INFORMATION

Patient's Name: (first) _____ (last) _____ (MI) _____

Patient's Date of Birth: ____/____/____ SS#: ____-____-____

Patient's Home Address: (street) _____

(town) _____ (zip code) _____

Patient's Housing Status: (check one) ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Own ☐ Rent

Primary Language: _____ What language do you speak and read? _____ Are you able to read? _____

Race (check all that apply):

	Black / African American		Caucasian		Native Hawaiian
	Asian		Pacific Islander		Refused
	Asian Pacific American		Subcontinent Asian American		
	Native American		American Indian or Alaskan Native		

Ethnicity (check one):

	Hispanic / Latino
	Non-Hispanic / Latino
	Refused

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown

Parent/Guardian Name: (first) _____ (last) _____ (MI)____

Relationship: _____ Date of Birth: ____/____/____

Address: _____ (town) _____ (zip code) _____

Home Phone: _____ Daytime Phone: _____ Cell Phone: _____

Email Address: _____

We can communicate with you through our Patient Portal. Please contact our office for more information.

Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Pharmacy: _____ Phone: _____

Office use only: ***School year 2018/2019***

School Code:	**NEW** Y / N	**RECALL:**	Staff member to: **SCAN DOCUMENT INTO Electronic file**

Revised: *7.30.2018 nh*

Patient Name_____ **DOB:**_____ **Pt#:**_____

Gender Identification / Sexual Orientation - At Generations Family Health Center, we want to take good care of you and your family. As a healthcare provider, there are certain questions we need to ask, to make sure we understand your needs. Please answer the questions below, the best that you can. **If you don't want to answer these questions, you don't have to**. As always, we keep any information you give us private. Thank you!

Gender at Birth: □ Male □ Female

Gender Identity: □ Refuse to answer □ Male □ Female □ Transgender Male □ Transgender Female □ Genderqueer □ Other

Sexual Orientation: ☐ Refuse to answer ☐ Lesbian ☐ Gay ☐ Straight ☐ Bisexual ☐ Other ☐ Unknown

Medical/Dental History *Please complete all information below. This information is required prior to the patient being seen.*

1. Does this patient have any health problems currently being treated by a doctor □ Yes □ No
   If yes, explain: _____
2. Does this patient currently have a primary medical care provider □ Yes □ No
   If yes, enter doctor's name and address: _____
3. Date of last physical exam: _____ Where was last exam done _____
4. Has the patient ever been seen by a dentist before □ Yes □ No
   If yes, where and when_____
5. Date of last dental exam _____ Date of dental x-rays, if ever_____
6. Has the patient ever been told by a physician/dentist to take medicine before a dental procedure □ Yes □ No
   If yes, please explain: _____
7. Is the patient taking any medication (including non-prescription, over-the-counter medication or herbal remedies)□ Yes □ No
   List all medications and dosages (attach a separate sheet if necessary) _____
   _____
8. Does your Child have a history of any of the following and If YES, please explain:

Y	N	Asthma		Stomach or bowel problems	Y	N
Y	N	Allergy to any foods or medications		Seizures or fainting spells	Y	N
Y	N	Allergy to pain medications (pills/Novocain)		Frequent Cough	Y	N
Y	N	Hospitalizations or Surgeries		Endocrine or hormone problems	Y	N
Y	N	Tuberculosis		Frequent headaches	Y	N
Y	N	Diabetes		Liver (Hepatitis)	Y	N
Y	N	Disabilities		Recurrent infections	Y	N
Y	N	Heart murmur or defect		Hives or skin rash	Y	N
Y	N	Rheumatic fever		AIDS or HIV infection	Y	N
Y	N	Bleeds or bruises easily		Anemia or Sickle Cell Anemia	Y	N
Y	N	Allergy to Latex (gloves or band aids)		Vision problems	Y	N
Y	N	Child pregnant (females only)		Hearing problems	Y	N
Y	N	Current dental problem		Kidney problems	Y	N
Y	N	Problems with a previous dental experience?		Severe dental trauma	Y	N
Y	N	Problems with learning or understanding instructions		Religious or cultural beliefs which the provider should consider in planning treatment	Y	N

9. How does the patient learn best? □ By reading □ By listening □ By demonstration □ By video □ Other: _____
10. Has the patient had / have any disease or condition not listed above? □ Yes □ No

If yes, explain: _____

FAMILY HEALTH HISTORY (please indicate family member with the following conditions)

Cancer (describe type) _____ Diabetes _____

Hypertension (high blood pressure) _____ Stroke _____

Mental Illness (anxiety, depression, etc.) _____ Heart Disease _____

Child and Family Health History Reviewed By:

Provider Signature: _____ ***Date :*** _____

Provider Signature: _____ ***Date :*** _____

Patient Name: _____ DOB: _____ Pt # _____

School Name: _____ Grade: _____

INSURANCE: Please provide all Insurance information requested and a copy of insurance cards.

	Dental Insurance	Medical Insurance	Behavioral Health Insurance	Secondary Insurance
Plan Name:				
Policy #				
Group #				
Subscriber Name:				
DOB:				
Relationship:				

If no Insurance, would you like to talk with our staff about coverage? ☐ Yes ☐ No

It is the policy of Generations Family Health Center, Inc. to provide essential services regardless of the patient's ability to pay. Discounts may be offered based upon family/ household size and annual income. Please complete the following information to determine if you or members of your family are eligible for a discount.

INCOME DOCUMENTATION

Family size: _____(including unborn child if pregnant)

Household gross income: $_____ per (circle one): WEEK BIWEEKLY MONTH YEAR

2018 FEDERAL POVERTY GUIDELINES ***(Effective January 17, 2018)***

INCOME RANGES:

Family Size	<100%	101-125%		126-150%		151-200%		201% and higher
		From	To	From	To	From	To	At or higher than 201%, does not qualify for slide
1	$ 12,140	$ 12,141	$ 15,175	$ 15,176	$ 18,210	$ 18,211	$ 24,280	$ 24,281
2	$ 16,460	$ 16,461	$ 20,575	$ 20,576	$ 24,690	$ 24,691	$ 32,920	$ 32,921
3	$ 20,780	$ 20,781	$ 25,975	$ 25,976	$ 31,170	$ 31,171	$ 41,560	$ 41,561
4	$ 25,100	$ 25,101	$ 31,375	$ 31,376	$ 37,650	$ 37,651	$ 50,200	$ 50,201
5	$ 29,420	$ 29,421	$ 36,775	$ 36,776	$ 44,130	$ 44,131	$ 58,840	$ 58,841
6	$ 33,740	$ 33,741	$ 42,175	$ 42,176	$ 50,610	$ 50,611	$ 67,480	$ 67,481
7	$ 38,060	$ 38,061	$ 47,575	$47,576	$57,090	$ 57,091	$ 76,120	$ 76,121
8	$ 42,380	$42,381	$ 52,975	$52,976	$63,570	$ 63,571	$ 84,760	$ 84,761

Each additional family member at $4,320

*The federal poverty guidelines are updated annually

Permission for Treatment/Annual Informed Consent

- I hereby voluntarily request and authorize Generations Family Health Center Dental Department to render dental services deemed necessary to my child by a registered dental hygienist and/or dentist.
- I will be informed of all treatment received and understand that I have the right to ask questions or refuse treatment at any time.
- I understand that you will bill my insurance. If I do not have insurance, I understand that I will be billed and that I am responsible for payment. I understand that I am able to make arrangements for a payment plan.
- I allow the release of information as needed for billing purposes and will request that the insurance company address claims by directing payment to Generations Family Health Center, Inc. It is my right to so assign these benefits.
- I give permission to share health information with the school and insurance companies as it relates to dental treatment that may be provided.

My signature below affirms my Annual Consent to the above Permission for Treatment. I also affirm that the information given on all parts of this form, including the Medical/Dental Health History and the Insurance and Income Information is accurate and complete to the best of my knowledge.

Parent or Guardian Signature: _____ Date: _____

Printed Signature: _____ Relationship: _____

NOTE: If you are a Legal Guardian, please attach copies of Court Documentation.