Lamoille Health Partners
Demographic Information

Patient Information *(*If patient is a minor, **Name** and **Number** of Parent or Legal Guardian)*

Last Name	*First Name*	*Date of Birth*	*Marital Status*

Physical Address	*Email Address*

Mailing Address	*Primary Language*	*Social Security Number*

Responsible Party	*Relationship to Patient*	*Primary Phone*

Insurance Information

Primary Insurance	*Insurance Phone*

Primary Insurance Address	*Group Number*

Subscriber Name	*Subscriber Date of Birth*	*Subscriber ID*

Other Information

Employer Name	*Work Phone*

Emergency Contact Name	*Emergency Contact Phone*

Pharmacy Name	*Pharmacy Number*

As a Federally Qualified Health Center we are required to collect the following information

Race: ☐ Asian ☐ Black or African American ☐ White ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Multiracial
☐ Other/Refused to Report ☐ Native Hawaiian ☐ Other Pacific Islander

Ethnicity:
☐ Hispanic/Latino ☐ Non-Hispanic ☐ Refuse to Report

Are you a Migrant Worker?
☐ Yes ☐ No

Are you a Seasonal Worker?
☐ Yes ☐ No

Are you a United States Veteran?
☐ Yes ☐ No

Are you homeless? ☐ Yes ☐ No
(If yes) ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other

The following household information is de-identified and is used to justify our federal funding:

Household size: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 or more

Yearly Household Income (please check one): ☐ Less than $22,340 ☐ $22,341–$30,260 ☐ $30,261–$38,180 ☐ $38,181–$46,100
☐ $46,101–$54,020 ☐ $54,021–$61,940 ☐ $61,941 or more If decline, initial here: ☐

I voluntarily authorize healthcare agents and employees of Lamoille Health Partners and their designees, as may in their professional judgment be deemed necessary or beneficial, to diagnose and treat my condition or the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures. I accept financial responsibility for all charges incurred as a result of such treatment. If insured, I authorize payment of medical benefits to the named provider for services rendered. I also authorize the release of medical information to process any claims.

By signing this form I certify that I understand the authorization to treat outlined above and have received the Patient's Bill of Rights and Responsibilities document and the HIPAA privacy information, and I accept these terms.

Patient or Guardian Signature _____ *Date* _____

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Lamoille Health Partners will have dental provider's present at your child's school throughout the year in our mobile dental unit. We will be able to provide the same comprehensive services that we offer in our Morrisville office.

The purpose of the dental program is to provide a dental home to students who do not currently have a dental home, this includes families who have not been seen in the past two years. If your child is seen at our Morrisville office, they can still be seen on the mobile dental unit.

Please check off all the services that you are permitting

- o Dental Cleaning
- o Application of Fluoride
- o Dental Exam
- o Sealants
- o Composite (White) Fillings
- o Extraction of Baby Teeth
- o Dental Radiographs/X-rays
- o Application of SDF

*SDF is a cavity treatment that stops progression of a cavity if we cannot complete a filling. The cavity/decay turns black after application.

Consent to Treatment

- I understand that by signing this form, I am consenting for the child's named above to receive the dental treatment that has been checked.
- I understand that this consent will stay in effect while my child attends this school, it will not need to be updated year to year.
- I understand that it is my responsibility to inform the dental provider and/or the school nurse of any changes in my child's medical information.
- I understand that all information about my child will be kept confidential.
- I further consent that my child's medical doctor and/or school official may release any medical information to Lamoille Health Family Dentistry's staff that may affect his/her dental treatment.
- Please update our office if there are any changes to your phone number or address at anytime so we can have the most up-to-date information to contact you regarding the follow ups.

By signing this form, I give consent for treatment and agree to the Financial Responsibilities previously listed. Forms that do not have a parent/guardian's signature will be returned.

I hereby give permission for _____ to have the above services completed by Lamoille Health Partners. Should you no longer want these services, please call our office at 802-888-7585.

Parent/Guardian Signature _____Date:_____

What School does your child attend? _____

Grade-_____

HEALTH INFORMATION

Name/Phone Number of Child's **Medical** Doctor:

IS YOUR CHILD TAKING ANY MEDICATIONS?	☐ Yes	☐ No

If yes, list medications:

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?					
Rheumatic Fever	☐ Yes	☐ No	Bleeding problems	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Sickle Cell	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No	High/ Low Blood pressure	☐ Yes	☐ No
Hepatitis / Liver	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Emotional disorder(s)	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Hearing/Speech Impaired	☐ Yes	☐ No			

** Please list known allergies, example: (latex, penicillin, metal, red dye, etc)

☐ No known allergies
☐ Yes: _____

DENTAL INFORMATION

Name of Child's Last Dentist:

Date of Child's Last Dental Visit:

Has your child had any of the following dental work performed below?

☐ Fillings ☐ Extractions ☐ Stainless Steel Caps ☐ Orthodontics (Braces)

Does your child have any current dental issues (toothache, loose tooth, swelling?) ☐ Yes ☐ No

If yes, please explain: