



AppHealthCare
Dental Health Center
225 Court Street | PO Box 208
Jefferson, NC
Phone: (336) 246-9449 ext. 2131
Email: dental.services@apphealth.com



August 19, 2025

Dear Parent/Guardian,

Welcome back to school, families!

AppHealthCare works closely with the school system to provide dental healthcare to students who do not currently have a dentist who sees them regularly. Using our portable dental van, we are able to provide basic dental care at the school so students don't have to miss school.

The Dental Team is staffed by a Dentist, Dental Hygienist, Dental Assistant and Management Support Specialist. We work closely with the AppHealthCare leadership team for services provided.

We are able to provide dental health care services for your child during the school day. This prevents your child from having to leave school for a medical appointment and allows you to remain at work during the day. We do not take the place of your regular dentist, if you already have one, and you do not have to change dentists to utilize our services.

If you are interested in having your child receive dental health care services at school through our portable dental service, please complete this enrollment packet entirely and include a copy of your child's health insurance card, if applicable. We are happy to make a copy of your child's insurance card at the Dental Health Center if you prefer. We look forward to working with you this school year to provide optimal care for your child. If you have any questions, please feel free to call the center at (336) 246-9449 extension 2131 or email us at dental.services@apphealth.com.

Thank you for allowing us to provide important healthcare services to your child.

Sincerely,

AppHealthCare Dental Health Center Team

To learn more about AppHealthCare, call us at (336) 246-9449 ext. 2131 or visit our website at www.AppHealthCare.com.
Follow us on Facebook and Twitter.

AppHealthCare: Caring for our Community

Last Updated: 07/2025

STUDENT PATIENT REGISTRATION
 Portable Dental Services - AppHealthCare
 Student Registration Form
 2025-26 School Year



Child's First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Gender (select one): Male Female

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

County: _____ Student Grade: _____ School: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method (select one): Home Phone | Work Phone | Cell Phone | Text Message (charges may apply)

Parent Name: _____ Parent SSN# or ITIN#: _____

Parent Email: _____ Homeroom Teacher: _____

<p>Race (select all that apply):</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Black, African American</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Other Pacific Islander</p> <p><input type="checkbox"/> American Indian or Alaska Native</p> <p><input type="checkbox"/> More than one race</p> <p><input type="checkbox"/> Unknown or decline</p> <p><input type="checkbox"/> Other</p>	<p>Ethnicity (select all that apply):</p> <p><input type="checkbox"/> Hispanic Latino</p> <p><input type="checkbox"/> Non-Hispanic Latino</p> <p><input type="checkbox"/> Decline to answer</p>	<p>Housing (select all that apply):</p> <p><input type="checkbox"/> Not homeless</p> <p><input type="checkbox"/> Homeless</p> <p><input type="checkbox"/> Decline to answer</p>
---	--	--

Preferred Language (select): English | Spanish | Other Language: _____

Country of Origin: _____

Emergency Contact Name (if different than parent/guardian)	Emergency Phone Number (NOT patient phone number)	Relationship to Patient

Date of Last Complete Physical: _____ If date unknown, check here:

Patient Healthcare Information - This information is used to send visit information to your primary care provider.

Primary Care Provider Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

If you do not have a dentist or medical provider, would you like to be seen at AppHealthCare for your healthcare and dental needs? Yes No

Preferred Hospital: _____

Preferred Pharmacy: _____ City: _____ Phone: _____

Please list all medications and doses your child is currently taking:

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Dental Insurance Information (check all that apply)

Medicaid

- Healthy Blue (BCBS)
- Wellcare
- AmeriHealth Caritas
- Carolina Complete
- Health Choice
- NC Medicaid Direct
- UHC

Other Commercial

- Blue Cross
- United Healthcare
- Delta Dental
- Metlife
- Principal

Uninsured or self-pay

Other (please specify): _____

CONSENT FOR SERVICE

Student Name: _____ Grade: _____ Date of Birth: _____

Student's Teacher: _____ Student's School: _____

I consent for the Portable Dental Program providers designated by AppHealthCare to provide or arrange services to meet the needs of myself/my child. These services may include any or all of the following:

- Comprehensive exams
- Limited exams
- Tele-dentistry exams
- Dental cleanings
- Dental sealants
- Fluoride application
- Dental screenings
- Oral hygiene instruction
- Nutritional counseling
- Radiographs (X-Rays)
- IntraOral Photos
- Silver Diamine Fluoride

The Portable Dental Program provided by AppHealthCare is available for all children who do not have a regular dentist.

Confidential Services

I understand that North Carolina General Statute 90-21.5 protects a minor's right to receive services related to sexually transmitted disease, pregnancy, drug abuse, and emotional disturbance without parental consent. I understand that medical providers are not allowed to notify the parent/guardian about services provided in these areas unless the situation, in the opinion of the medical provider, indicates that notification is essential to the life or health of the minor. I further understand that the AppHealthCare staff will make every effort to encourage my child to discuss problems and services with me.

For services not designated as confidential, I understand that I will be informed and will be asked to authorize my child's treatments other than medical or over-the-counter treatments. In the event my minor child requires urgent medical care and I cannot be reached, I request that my child be allowed to authorize his/her own care with the understanding that I will be contacted as soon as possible. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL ASPECTS OF MEDICAL CARE IF FOLLOW-UP OR REFERRAL TO ANOTHER PROVIDER IS RECOMMENDED.

Medical Records Confidentiality

I give permission for information in the medical record to be shared with my primary care provider in order to coordinate care. In order to protect the confidentiality of the services provided through the AppHealthCare, I request that my child's record be kept confidential and not be released, except as authorized, to me or anyone else without my/my child's consent. I understand that my child's record is the property of AppHealthCare and that the information within will be kept confidential in accordance with state laws and accepted medical practice.

Release of Information for Payment

I give permission for information in medical records to be used for billing third party payers, such as Medicaid or other insurance and for program management and evaluation purposes on a strictly confidential basis in accordance with the law and acceptable medical practice. This consent to release information authorizes AppHealthCare to release to any third payer indicated to be responsible for payment for this period of treatment and release of information from my health record, or any other information, to verify eligibility and confirm benefits, and secure payment of charges, both during and after my visit.

Assignment of Insurance Benefits

I hereby authorize payment directly to AppHealthCare of insurance benefits otherwise payable to me including medical and surgical benefits, not to exceed the reasonable and customary charge for these services rendered by said facility. I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions whereby coverage is subject to a coordination of benefits clause.

Medicaid Patient Certification

I certify that the information given by me in applying for payment under Medicaid guidelines and Title XIX of the Social Security Act is correct and request that payment of authorized benefits be made on my behalf

Validity

This authorization is valid for the length of time necessary to process claims for the incurred charges. This consent to treatment and care shall remain effective until the student departs from the school or age 22, unless sooner revoked in writing and delivered to AppHealthCare.

I understand that by signing this document I authorize my child to receive services offered by the AppHealthCare Portable Dental Program.

*I understand that I may revoke this consent at any time.

*I understand that I may decline any services either by verbal or written request to the staff at AppHealthCare.

*I understand that this consent is voluntary and valid for the entire time that my child is enrolled in the school system, provided that I give up-to-date medical insurance and registration information each school year or as needed.

By signing this statement, I confirm that I have received, read, and understand the following documents:

1. Registration and Consent for Services Forms
2. Billing, Insurance, and Collection Consent Policy
3. Parents & Students Rights and Responsibilities
4. Notice of Privacy Practices

Signature of Parent/Legal Representative

Date

Student Health History Form

Student Name: _____ Date of Birth: _____

Please check any of the below conditions or health concerns your child has or has had in the past.

- | | | |
|--|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Head injury | <input type="checkbox"/> Pregnancy (current) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Blood disease/sickle cell | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous disorders | <input type="checkbox"/> Tobacco, smoking or vape use |
| <input type="checkbox"/> Fear of the dentist | <input type="checkbox"/> Pink eye (conjunctivitis) | <input type="checkbox"/> Ulcers |

Does your child have allergies to any of the following? Please check all that apply.

- Latex products
- Anesthesia
- Penicillin
- Codeine
- Other allergies: _____

Does your child have any serious illness(es) that are not listed above? If yes, please describe.

- Yes No Describe: _____