Molly Stark Preventative Dental Hygiene Clinic
Molly Stark Elementary School
Bennington, VT 05201

Registration for Dental Services

Please fill out this form as completely as possible so we can provide the best possible dental care for your child.

Child's Name_____ **Date of Birth** ___/___/___

Social Security # _____ **Male**_____ **Female**_____

Parent/Legal Guardian Name:_____**Relationship**_____

Mailing Address _____

Town_____**State** _____ **Zip:**_____ **Email:**_____

Phone: Home_____Work_____Cell_____
Circle preferred telephone number to call

Person to notify in case of emergency, if we are unable to reach parent/legal guardian:
Name_____ Relationship_____

Phone: Home_____Work_____Cell_____
Circle preferred telephone number to call

Teacher Name_____

Does your child have Medicaid/Dr. Dinosaur? YES NO

Does your child have private medical insurance? YES NO Insurance Name:_____

Does your child have private dental insurance? YES NO Insurance Name:_____

Do you need help signing up for insurance? YES NO

What is your race? (Select One or More) White_____ **American Indian/Alaskan Native**_____
Asian____ **Black or African American**_____**Native Hawaiian or Other Pacific Islander**_____
Are you Hispanic or Latino? YES NO

Do you require an interpreter? YES NO Preferred language? _____

Please circle if you are: Homeless
Please circle household size:1 2 3 4 5 6 7 8 9 10 or write in #_____

What is your annual (yearly) family household income? _____

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Dental and Medical History

Dental History:

Name of your child's current Dentist: _____ Date of Last Visit:_____
Have there been any injuries to your child's teeth, mouth or head in the last year? Yes No
Has your child had any unpleasant experiences in dental or medical office? Yes No
Do you have any special concerns about your child's teeth, gums or mouth? Yes No
If yes to any of above, describe:_____
Is your child currently taking a fluoride supplement? Yes No
Does your child suck his/her thumb, fingers, pacifier? Yes No
How many times are your child's teeth brushed per day? _____
What type of water does your child drink? Town Well Bottled
Please describe your child's temperament by circling one or more of the following:
Friendly Talkative Shy Nervous Active Has behavior problems

Medical History:

Name of your child's current doctor or primary care provider: _____
Is your child taking any prescription or over the counter medications?
If yes, please list_____
Does your child have any allergies?
If yes, please list_____
Has your child ever been hospitalized? Yes No
If yes, when_____ reason_____

Please place a check mark if your child has ever been diagnosed with any of the following:

Anemia	Brain Injury	Hearing loss/aids
Arthritis/Rheumatism	Brain Surgery	Heart problem/surgery
Allergies	Cancer	Heart Murmur
Artificial Heart Valve	Chemotherapy	Hemophilia/bleeding disorder
Artificial Joints	Cerebral Palsy	Hepatitis, type_____
Asthma	Cleft lip/palate	High/low blood pressure
ADD or ADHD	Diabetes	HIV/AIDS
Autism	Eye Problems	Fainting
Birth Defects	Kidney Problems	Rheumatic Fever
Epilepsy/seizure disorder	Tuberculosis	Behavior/Learning Disability

Does your child have any other problems or concerns not listed?

_____
_____
_____
_____

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Consent to Treat a Minor

On behalf of my minor child, _____, I authorize the dental staff of the **Molly Stark Preventative Dental Hygiene Clinic** to perform the following routine dental hygiene procedures on my child:

___ Examination including X-Rays
___ Cleaning
___ Fluoride Treatment
___ Sealants

If there are any procedures you do not wish to have performed, please cross off and initial.

- **I understand that the dental hygienist will provide a written report of any hygiene services provided, with instructions as needed.**
- **If my child is found to be in need of additional services, the staff of the Molly Stark Preventative Dental Hygiene Clinic will contact me to discuss a referral to a local dental home.**
- **I consent to the use of my child's protected health information by the Molly Stark Preventative Dental Hygiene Clinic for the purpose of coordinating dental care.**
- **I understand that no photographs will be taken of my child without additional consent.**
- **By signing this consent, I also acknowledge that the Molly Stark Preventative Dental Hygiene Clinic is a program of Greater Bennington Interfaith Community Services, Inc. (d/b/a Bennington Free Clinic), a nonprofit entity that provides free health care services and is qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. I further acknowledge that I have been notified that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. Sections 1346(b), 2401(b), 2671-80) provides one remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental or related functions by those free clinic volunteer health care practitioners who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage is limited, and applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. Section 233(a)(o)). Certain free clinic health care practitioners providing health care services to patients at this free clinic may be covered by the above Federal law.**
- **I understand that this consent form is active for as long as my child is receiving dental care at Molly Stark Elementary School.**
- **I certify that all the information I have given is correct, true and complete.**

_____

Signature of patient or legal guardian **Date/Time**