Las Clinicas del Norte

SCHOOL BASED DENTAL PROGRAM ENROLLMENT FORM

My child is a student at:

- ☐ El Rito Elementary
- ☐ Mesa Vista Elementary
- ☐ Mesa Vista Middle School
- ☐ Mesa Vista High School
- ☐ Pojoaque Elementary
- ☐ Pojoaque Intermediate
- ☐ Pojoaque Middle School
- ☐ Pojoaque High School
- ☐ Pojoaque 6th grade academy
- ☐ La Tierra Montessori

STUDENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Home Address (PO Box, City, ST, ZIP):			
Social Security No.:	Home Phone:	Cell Phone:	
Birth Date:	Race:	Hispanic/Latino: Yes ☐ No ☐	Male ☐ Female ☐
Grade:	Teacher/Homeroom:		

PARENT INFORMATION		
Last Name:	First Name:	Middle Name:
Address (If different from student):		
Work Phone:	Home Phone:	Cell Phone:
Additional Contact Information:		Phone:
Relationship to student:		

INSURANCE INFORMATION *(Please give your card to the receptionist)*	
Does your child have Dental Insurance? Yes ☐ No ☐	Insurance Company:
Policy #:	Group #:
Insurance Billing Address:	
Policy Holder Name:	Policy Holder Birth Date:
Name of Doctor:	Phone #:
Name of Dentist:	Phone #:
Date of last dental visit:	Date of next cleaning:

I give permission for my child, named above, to receive SBHC services and for SBHC staff to access my child's class schedule (for appointment purposes only). I also give permission for the SBHC staff to consult with and provide information and records to other medical/dental care and mental health providers, including school health professionals, and for purposes of program evaluation and quality assurance. I understand that health records are confidential and will not be open to the school or other outside personnel unless the parent/guardian gives written consent, or in the case of treatment for which the minor has given consent, unless the minor gives written consent. I have received a copy of LCDN notice of privacy. I also understand the New Mexico law does not require parental consent for treatment or advice about sexually transmitted diseases, pregnancy or contraception to minors under 18 years of age and behavioral health counseling services to minors age 14 years or older. I hereby authorize LCDN to bill my insurance. I authorize payment directly to LCDN of all insurance benefits otherwise payable to me for services rendered to myself or my dependents. I authorize LCDN to release any information concerning my dependent's illness and treatment, including conveyance of such information by electronic means, required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Parent/Guardian	Date
Signature of patient, if 18 years or older	Date

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Name:	Birth Date:

MEDICATION & ALLERGY INFORMATION		
List all medications your child takes daily or on a regular basis		
Medication:	mg:	Directions:
Medication:	mg:	Directions:
Medication:	mg:	Directions:
Medication Allergies: Yes ☐ No ☐ Name of medication(s):		
Reaction to medication(s):		
Food Allergy: Yes ☐ No ☐ Source of allergy:		
Does your child have a doctor's order for an Epipen? Yes ☐ No ☐		

DENTAL HISTORY: Please circle YES or NO

YES **NO** Has your child complained of mouth pain within the last six months?

YES **NO** Does your child routinely visit a dentist for six month check ups?

YES **NO** Do you need help in finding a dentist?

Check all that apply	**Does your student have any of the following conditions?**	**ADDITIONAL INFORMATION** To help us better serve your child's dental needs
	ADD/ADHD	
	Asthma/Wheezing/Breathing	
	Bleeding disorder	
	Cancer	
	Depression/Mental Illness	
	Developmental Disabilities	
	Diabetes	
	Drug/Alcohol/Tobacco Use by Student/Household	
	Hearing/Vision Problems/Loss	
	Heart Problems	
	HIV/AIDS	
	Joint Replacement	
	Lead Poisoning	
	Liver Problems (Hepatitis)	
	Seizure Disorder (Epilepsy)	
	Tuberculosis	
	Any other health issues	

Reviewed by: _____