Community Health Center, Inc. is at your school!

In-School Services Provided

Medical Care:

- Diagnosis and Treatment
- Physical Exams
- Chronic Disease Management
- Immunizations
- Prescriptions
- Health Education
- Referrals
- Labs

Behavioral Health:

- Crisis Intervention
- Individual Counseling
- Group Counseling
- Family Counseling
- Referrals

Oral Health:

- Screenings
- Exams
- Cleanings
- X-Rays
- Sealants
- Oral Health Education
- Restorative Care

Community Health Center, Inc.
SBHC
School-Based Health Center

Please keep this sheet for your records.

***Questions or concerns?* Call 860-347-6971 ext: 3796.**

You can also enroll online: **http://www.sbhc1.com**

School-Based Health Services are a division of Community Health Center, Inc. www.chc1.com | Facebook/CHCInc | Twitter(@CHCConnecticut)

Comprehensive Enrollment Form

SBHC School-Based Health Center

860-347-6971 ext. 3796

Community Health Center, Inc.

I give permission for my child/self to obtain MEDICAL SERVICES. ❑ YES ❑ NO

- All insurances will be billed at time of visit. No out of pocket fees or copays associated with services rendered in school.

I give permission for my child/self to obtain BEHAVIORAL HEALTH/COUNSELING SERVICES (if available). ❑ YES ❑ NO

- All insurances will be billed at time of visit. No out of pocket fees or copays associated with services rendered in school.

I give my child/self permission to obtain ON-SITE MOBILE DENTAL SERVICES. ❑ YES ❑ NO

For patients enrolled in HUSKY/Medicaid, services are 100% covered with no additional fees or charges.
For patient with private dental insurance, services are billed to insurance. Patient/Family is only responsible for any deductible and/or co-pay.
For patients with no dental insurance the following fees apply:

- **$30 for Dental Hygiene visit (cleaning, x-rays, fluoride); $25 per visit for sealants; $18 per visit for exam by the Dentist**

RISKS: Although infrequent, some risks and complications are known to be associated with dental procedures. The most common include biting and injuring tongue or lip following the administration of local anesthesia and soreness around the area being treated. Additional risks include infection and swelling.

I certify that the health information provided is accurate to the best of my knowledge and understand that incorrect information can be dangerous to the student/patient's health. I will notify CHC of any changes to medical information. ❑ YES ❑ NO

I have received a copy of CHC's Rights and Responsibilities Policy. ❑ YES ❑ NO

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION: ❑ YES ❑ NO

I authorize the release of any medical, dental or behavioral health information necessary to process my claim. I also authorize payment of health benefits to Community Health Center, Inc. for services provided.

CONSENT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES: ❑ YES ❑ NO

I consent to the use or disclosure of my protected health information by CHC to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information use or disclosed to CHC may include HIV/AIDS related information, psychiatric/mental health information, drug/alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how CHC will use and disclose my information can be found in CHC's Notice of Privacy Practices. I understand my consent is effective for as long as CHC maintains my protected health information.

AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION: ❑ YES ❑ NO

I hereby authorize Community Health Center, Inc. (CHC) to exchange health and education records with my child's school district for the purpose of providing care and treatment to my child, if applicable.

PATIENT INFORMATION

*** Required information.**

Full Legal Name: _____ (First / Middle / Last) Date of Birth: _____

Street Address/Apt #: _____ City: _____ ZIP: _____

Sex: ❑ Male ❑ Female Social Security Number: _____ Ethnicity (check box): ❑ Hispanic ❑ Non-Hispanic

Race (check box): ❑ Unknown ❑ American Indian ❑ Pacific Island ❑ Alaskan Native ❑ Black ❑ Asian ❑ White ❑ Other _____

Patient's Primary Language: _____ Does the patient qualify for free/reduced lunch?: ❑ Yes ❑ No

School Patient Attends: _____ Grade: _____

Primary Care Provider's Name: _____ Phone Number: _____

Dentist's Name: _____ Phone Number: _____

INSURANCE INFORMATION

*** Medical Insurance:** _____ *** Medicaid ID #:** _____ *** Private Ins. ID/Policy #:** _____ *** Group Number:** _____

*** Insurance Address:** _____ *** Insurance Phone Number:** _____ (info on back of card)

*** Policy Holder Name:** _____ *** Policy Holder DOB:** _____

*** Dental Insurance:** _____ *** Private Ins. ID/Policy #:** _____ *** Group Number:** _____

*** Insurance Address:** _____ *** Insurance Phone Number:** _____ (info on back of card)

*** Policy Holder Name:** _____ *** Policy Holder DOB:** _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to Patient: _____ DOB: _____

*** Street Address/Apt #:** (If different from above): _____ City: _____ ZIP: _____

I agree that messages can be left for me on: ❑ Home Phone ❑ Cell Phone ❑ Work Phone

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

Student's Cell Phone: _____ Student's Email Address: _____ Email Address of Parent/Guardian: _____

EMERGENCY CONTACT (If different than Parent/Guardian)

Name: _____ Relationship to Patient: _____ Phone Number: _____

*** Signature of Parent/Legal Guardian or Student if over 18 years old:** _____

*** Print Name:** _____ **Date:** _____

By signing above, I understand and acknowledge that I have read and understand this consent and I have received CHC's Notice of Privacy Practices currently in effect. I also understand that this authorization is valid until I revoke this authorization. I understand I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records if received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by Family Education Rights and Privacy Act.

Student/Patient Medical History *(For Dental, this medical history will need to be updated every four years.)*

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

Does the patient have any medical conditions?	❑ YES ❑ NO	Explain:
Does the patient take any medications? (including inhalers)	❑ YES ❑ NO	List all medications:
Has the patient had any serious injuries?	❑ YES ❑ NO	Explain:
Does the patient have a birth or heart defect or have history of a heart problem or surgery?	❑ YES ❑ NO	Explain:
Has the patient ever been hospitalized overnight?	❑ YES ❑ NO	Explain:
Has the patient had any surgery in the past?	❑ YES ❑ NO	Explain:
Has the patient had any shunts placed or has an indwelling catheter?	❑ YES ❑ NO	Explain:
Is/was the patient a teen parent?	❑ YES ❑ NO	
Is the patient pregnant or possibly pregnant?	❑ YES ❑ NO	Due date:
Is the patient currently nursing?	❑ YES ❑ NO	
Is premedication with antibiotics needed prior to dental procedures?	❑ YES ❑ NO	Explain:
Does the patient smoke or chew tobacco?	❑ YES ❑ NO	

Does the patient have or had any of these PROBLEMS?

Anemia/blood disorders	❑ YES ❑ NO	Pneumonia	❑ YES ❑ NO
Asthma	❑ YES ❑ NO	Rheumatic fever, heart disease, murmur	❑ YES ❑ NO
Autism	❑ YES ❑ NO	Scoliosis	❑ YES ❑ NO
Bladder or kidney infections	❑ YES ❑ NO	Seizures	❑ YES ❑ NO
Cancer/leukemia	❑ YES ❑ NO	Thyroid disease	❑ YES ❑ NO
Chicken pox	❑ YES ❑ NO	Tuberculosis	❑ YES ❑ NO
Diabetes	❑ YES ❑ NO	Ulcer/digestive problem	❑ YES ❑ NO
Eating issues	❑ YES ❑ NO	Any mental health issues?	❑ YES ❑ NO
Endocrine/gland disease/ autoimmune disease	❑ YES ❑ NO	Any birth or congenital defects (spina bifida, brain, heart, lung, etc.)?	❑ YES ❑ NO
Headaches/migraines	❑ YES ❑ NO	Any problems with teeth?	❑ YES ❑ NO
Hepatitis or liver problems	❑ YES ❑ NO	Any teeth causing pain?	❑ YES ❑ NO
Learning/developmental issues	❑ YES ❑ NO	Any bleeding when brushing or flossing?	❑ YES ❑ NO
Mononucleosis	❑ YES ❑ NO	Had a dental cleaning within the last 6 months?	❑ YES ❑ NO
Overweight/obesity	❑ YES ❑ NO	Other:	❑ YES ❑ NO

ALLERGIES

Any foods (including lactose intolerance)	❑ YES ❑ NO	Comment:
Any medications (including over the counter or antibiotics; penicillin or amoxicillin)	❑ YES ❑ NO	Comment:
Local anesthetics (including lidocaine) or latex	❑ YES ❑ NO	Comment:
Does the patient have an Epi-Pen at school?	❑ YES ❑ NO	Comment:
Other:		Comment:

BEHAVIORAL HEALTH Please complete ONLY if patient is in need of behavioral health services

Would you like to enroll the patient in behavioral health services? ❑ YES ❑ NO

Has the patient ever had counseling services? ❑ YES ❑ NO If yes, when and with whom?

Has the patient ever had any of the following:

Family changes	❑ YES ❑ NO	Anger issues	❑ YES ❑ NO
School issues	❑ YES ❑ NO	Attention difficulties	❑ YES ❑ NO
Social/peer stresses	❑ YES ❑ NO	Sadness and/or mood swings	❑ YES ❑ NO
Anxiety	❑ YES ❑ NO	Truancy/school avoidance	❑ YES ❑ NO
Learning disabilities	❑ YES ❑ NO	Recent loss	❑ YES ❑ NO

If answered yes to any of the above, please comment: