CLINICA FAMILY HEALTH CONFIDENTIAL PATIENT REGISTRATION-SCHOOL BASED HEALTH CLINIC 2022-2023

BVSD and Clinica Family Health will be providing preventative dental services throughout the school year. All students can receive this dental care regardless of dental insurance. If your child has Medicaid, CHP+ or Cigna Dental, Clinica will bill these insurances for care provided. **Families who complete the insurance and income portion of this consent form will not be subject to any out of pocket costs.** All information is confidential. Children will have their teeth and gums checked for potential problems and the parents will be informed if a child has any cavities or needs further treatment by a dentist.

I give my permission and authorize a dental screening/evaluation. ☐Yes ☐No
I give permission for my child to have fluoride varnish applied to their teeth. ☐Yes ☐No
I give permission for my child to have sealants applied to their teeth. ☐Yes ☐No

Does your child have allergies or any medical conditions? ☐Yes ☐No
Please explain if answered Yes:_____

A copy of Clinica's Notice of Privacy Practices is attached hereto and can also be found at https://www.clinica.org/patient-information/patient-privacy.html.

My Child Attends:

Emerald Elementary ☐ Sanchez Elementary ☐ Columbine Elementary ☐ Creekside Elementary ☐
Ryan Elementary ☐ Pioneer Elementary ☐ University Hill Elementary ☐ Lafayette Elementary ☐

Grade Level (2022-2023 school year)_____

I, _____, acknowledge receiving and reading a complete copy of the Notice of Privacy
Parent/Guardian Name
Practices of Clinica Family Health on _____ I further acknowledge that, as of today's date, I have no questions
Date
regarding the Notice of Privacy Practices.
Parent/Guardian Signature:_____ Date:_____

Clinica is a federally qualified health center. As part of our grant requirements, we are required to collect all of the information below.
Student Last Name: _____ Student First Name: _____ Student Middle Name: _____

Date of Birth: _____/_____/_____ Age: _____ Sex at Birth: ☐Female ☐Male
Month / Day / Year
Parent/Guardian Name: _____ Relationship to Patient: _____ Parent/Guardian date of birth: _____

Street Address: _____
City: _____ State: _____ Zip Code: _____ County: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____ Email: _____
Primary Language: _____ Language Barrier: ☐Yes ☐No Interpreter needed: ☐Yes ☐No

Family Size: _____ Household Income: $_____ per: (Circle one) WEEK 2 WEEKS MONTH YEAR
Type of dental insurance? ☐Medicaid ☐CHP+ ☐Delta Dental ☐None ☐Other
Medicaid/Insurance Policy Number:_____

Do you receive housing assistance or live in public housing? ☐Yes ☐No
Do you consider yourself **homeless**? ☐Yes ☐No
If you answered Yes to the above question please check the box below that most describes your living situation:
☐ Homeless Shelter
☐ Doubling up (sharing a home with another family, not paying rent)
☐ Other situation (not renting, owning, or living in someone else's home)
☐ Transitional living situation (between homes)
☐ Living on the street
Are you a Migrant or Seasonal Farm worker or a child of a Migrant or Seasonal Agricultural worker? (The term "agriculture" means farming in any of the following settings including any type of crop: planting, cultivating, harvesting, transporting produce, loading produce, or working farm stands.): ☐Yes ☐No

If you answered Yes to the above question; which are you: ☐Seasonal Worker ☐Migrant Worker (moves from harvest to harvest though out the state/ country)

Race	
☐ White	☐Black/African American
☐Asian	☐Other Pacific Islander
☐Native Hawaiian	☐American Indian/Alaskan Native
☐I do not care to report	

Gender Identity (Can be kept confidential)	
☐Male	☐Other
☐Female	☐Choose not to disclose
☐Transgender Female (MtF)	☐Transgender Male (FtM)
Pronouns:	Pronouns:

Sexual Orientation	
☐Straight (not Lesbian or Gay)	☐ Bisexual
☐ Lesbian or Gay	☐Don't know
☐ Choose not to disclose	☐ Other

Ethnicity	
☐I am Hispanic/Latino	☐I am not Hispanic/Latino
☐I do not care to report	

In order for us to provide you with medical, dental, behavioral and telehealth healthcare, we are required to obtain consent from you. By signing and providing consent, you as a patient still have the right to choose what services and care you receive. Refusing to sign this form prevents us from seeing you as a patient. Your consent is valid for 1 year from date of signing.

By providing my contact number I agree to receive calls or texts on behalf of Clinica Family Health. Calls will be made using manual or automatic dialing/texting system at the phone number(s) provided on this form. All calls/texts placed will be regarding treatment, payment or healthcare operations provided by Clinica Family Health only and will include calls/texts to any person listed on this form. **These calls/texts may contain personal health information about my treatment**. I understand I may opt out of receiving manual or automatic dialing/texting information by providing Clinica Family Health a written request to be removed from the manual or automatic dialing/texting system or opting out via the autodial opt out offered when you receive an autodialed call/text.

By signing, I hereby give permission for Clinica Family Health to provide healthcare services to all persons listed on this form. This includes permission to bill my insurance company or others who are responsible to pay for my healthcare services and for the release of any medical records needed to obtain payment for these services.

Patient or Parent/Guardian (If under 18 years of age) Signature:

_____

Today's Date:

_____