School-Based Patient Registration Paperwork

Great Mines
HEALTH CENTER

Attached is your new school based patient paperwork necessary.

You will need to RETURN a copy of the following:

- Driver's License or Photo Id
- Insurance Cards
- Signed Registration Forms
- Copays

If you do **NOT** carry insurance or choose to not use your insurance please be sure to provide us with your proof of income. This needs to be **MONTHLY HOUSEHOLD INCOME.**

EXAMPLES:

- Check Stubs
- Bank Statements
- Tax Return
- Social Security, Child Support, Food Stamps
- Unemployment

We look forward to assisting you!!

Main Location:	Farmington Location:	School-Based Services
#1 Southtowne Dr	508 West Pine St	Call (573) GET-WELL
Potosi, MO 63664	Farmington, MO 63640	438-9355
(573) 438- 9355	(573) 664-1100 Dental	
	(573) 664-1221 Medical	

School Based Health Center Fact Sheet

What is a School Based Health Center?

School-Based Health Centers are health clinics that bring preventive and immediate care, as well as counseling, health education, and sometimes dental care, to children and adolescents at schools.

Overview of SBHC:

Description of services offered

Hours & Coverage: The SBHC is open when school is in session. Please call for hours. Although appointments are preferred, students may be seen on a walk-in basis, depending on the problem and availability of the staff. If necessary, appointments are available before or after school. If a student or parent does not have a primary care provider he/she will have phone access to health care providers during the evening, weekends and vacations by dialing the GMHC main number phone number 573-438-9355. A recorded message will direct the caller to the provider on call.

Staffing: The staff at Great Mines Health Center's SBHC are highly qualified and experienced in providing health care to young people. The Nurse Practitioner, Dental Hygienist and Licensed Clinical Social Worker work in collaboration with a physicians and dentists and are qualified to diagnose and treat a variety of healthcare needs. The Nurse Practitioner is able to prescribe medications. The SBHC staff work with, but do not replace your family doctor or school nurse, however Great Mines Health Center would be happy for you to become an established medical, dental or behavioral health patient of the health center!

Billing & Costs: No student will be denied access to health care services due to inability to pay at the time of service. As in any health center, there may be a charge depending on the service provided and the parents or guardians will be billed for their child's treatment and will be responsible for payment. Patients/parents are responsible for insurance co-pays and unmet deductible amounts. Students eligible for the free/reduced lunch program may qualify for CHIPS or Medicaid. Information about various programs and how to apply is available from the health center staff. The SBHC depends upon the ability to collect payment from your insurance carrier in order to maintain the current hours of the SBHC.

GREAT MINES HEALTH CENTER ENROLLMENT AND CONSENT FORM

#1 Southtowne Drive, Potosi Missouri 63664

573-438-9355

STUDENT INFORMATION *

Student Name: _____ Student SS #: _____

Address: _____Email Address _____

City/State/Zip: _____

Cell:_____ **Text Appointment Reminders: Yes or No** Home Phone:_____

Grade: _____ Birth date: _____

Gender: *Female or Male* **Race**: *White, African-American, Hispanic or Other if so list:* _____

Ethnicity: *Hispanic/ Latino or Non-Hispanic/Latino* **Preferred Language**: *English or Other* _____

Sexual Orientation: *Straight, Lesbian/Gay, Bisexual, Other, Don't Know, Prefer not to answer*

Gender Identity: *Male, Female, Transgender M/F or F/M, Other, Prefer not to answer*

Housing Status: *Home, Doubling Up, Transitional Housing, Homeless, or Public Housing, Other*_____

PARENT / GUARDIAN INFORMATION

Father: _____ Phone (H)_____ (W)_____ (C) _____Email _____

Mother: _____Phone (H)_____ (W)_____ (C) _____E-mail_____

Guardian: _____Phone (H)_____ (W)_____ (C) _____E-mail_____

Alternate Contact:_____Phone (H)_____ (W)_____ (C) _____E-mail_____

CONSENT FOR GMHC-SBHC (School Based Health Center) SERVICES

I, the parent/guardian of said student, give consent for my child to receive services at Great Mines Health Center's SBHC. I understand that this consent form will be effective until my child leaves or graduates from the District, or until I provide the Center staff with written revocation of this consent.

All healthcare information is confidential. By signing the consent form you are giving the SBHC and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner.

No student will be denied access to health care services due to inability to pay at the time of service. As in any health center, there may be a charge depending on the service provided and the parents or guardians will be billed for their child's treatment and will be responsible for payment. When available, insurance or Medicaid will be billed. I understand and agree that SBHC may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents and the health center is assured. I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above-named child will be shared between the medical provider and the alternative contact.

_____ _____

Signature of Parent / Legal Guardian Date

Health Information *(Additional health, family & developmental history may be collected by your site)*

1. Please provide any medical/dental/behavioral information that we should know about your child (allergies, medications, chronic illnesses, surgeries, etc.) _____
2. Doctor's name / phone number: _____
3. Please initial here if you would like your child to have a physical exam completed at the SBHC: _____ My child has not had a physical exam within the last year. If time allows, I would you like my child to have a comprehensive physical exam during the school year.
4. How often does your child go to the dentist? At least once a year___ Only with toothaches___ Never___
5. When was your child's last dental exam? Name of Dentist: _____
6. Please initial here if you would like your child to have a dental exam completed at the SBHC: _____ My child has not had a dental exam within the last year. If time allows, I would you like my child to have a comprehensive dental exam during the school year.
7. Please initial here if you would like your child to have a consultation with the Licensed Clinical Social Worker at the SBHC _____.
8. If we need to call in a prescription, which pharmacy would you like us to call? _____
9. Immunizations:
   - ☐ Immunization Record Is Attached
   - ☐ I give my permission for you to obtain my child's immunization record

   Signature: _____ Date: _____

Child's Insurance Information – ***Please check all that apply and send a copy of the front and back of your insurance card(s)***

☐ **Primary MEDICAL Health Insurance:**

Name of Insured Parent / Guardian _____
Birth date of Card Holder SSN of Card Holder _____
Address (if different from child) _____
Place of Employment _____
Name of Insurance Company _____
Insurance Address _____
Insurance Phone / Fax Number _____
Group & ID Number _____

☐ **Secondary MEDICAL Health Insurance**:

Name of Insured Parent / Guardian _____
Birth date of Card Holder SSN of Card Holder _____
Name of Insurance Company _____
Insurance Address _____
Insurance Phone / Fax Number _____
Group & ID Number _____

☐ **Medicaid: Mo HealthNet Home State Missouri Care United Healthcare (please circle one)**

Medicaid ID#: Member ID# _____
PCP/HMO Provider: Provider Phone Number: _____

☐ **CHIP:** Name on Card: Birth date of card holder: _____
ID or PIN # on card: Group #: _____

☐ **No health insurance / Request application for sliding fee / CHIP / Medicaid**

☐ **Primary Dental Insurance**:

Name of Insured Parent / Guardian

Birth date of Card Holder SSN of Card Holder

Name of Insurance Company

Insurance Address

Insurance Phone / Fax Number

Group & ID Number

☐ **Secondary Dental Insurance**:

Name of Insured Parent / Guardian

Birth date of Card Holder SSN of Card Holder

Name of Insurance Company

Insurance Address

Insurance Phone / Fax Number

Group & ID Number

☐ **Medicaid: Mo HealthNet Home State Missouri Care United Healthcare (please circle one)**

Medicaid ID#: Member ID# _____

PCP/HMO Provider: Provider Phone Number:

☐ **No health insurance / Request application for sliding fee / Medicaid**

Great Mines Health Center

Medical Health History

Please be aware that not providing an accurate health history may result in a negative health outcome. Complete historical information is necessary for providers to appropriately treat your medical condition. Thank you

Name: _____ DOB: _____

ALLERGIES: _____ Date of last Tetanus:

Family History: If any blood relative has suffered any of the following, please indicate which relative:

Epilepsy: _____	Migraine: _____	Mental Illness: _____
Glaucoma: _____	Diabetes: _____	Thyroid Disease: _____
Hay fever: _____	Asthma: _____	Anemia: _____
Cancer: _____	Osteoporosis: _____	Arthritis: _____
Heart Disease: _____	Stroke: _____	Hypertension: _____
Lipid Disorder: _____	Alcoholism: _____	Hepatitis: _____

Hospital Admissions:

Year Illness or Operation

_____

_____

_____

List all Medications you are currently taking: (please use reverse side if needed)

_____

_____

Please list any assistive devices you use:

_____

Medical History- Please circle if you have or have had any of the following:

Heart Murmur	German measles	Thyroid Disease	Rheumatic Fever
Pneumonia	Stroke	Crohn's Disease	Polio
Polio	HIV/AIDS	Anemia	Depression
Osteoporosis	Chickenpox	Measles	Glaucoma
Colitis	Arthritis	Herpes	Other: _____
Gout	Ulcer	Blood Disease	
Alzheimer's disease	Rheumatism	Eczema	
Artificial Heart Valve	Artificial Joint	Mumps	
Heart Pacemaker	Heart Attack/Failure	Blood Transfusions	
Scarlet Fever	Alcoholism	Hepatitis A, B, C	
Chronic Fatigue	Diverticulosis	Diabetic	
Sexually Transmitted Disease	High Blood Pressure	Seizures	
Psoriasis	Tuberculosis	Anaphylaxis	
Cancer: _____		Hernia	

Social History:

Do you drink alcohol? Yes or No if yes, how much do you consume in one week? _____

Do you smoke? Yes or No if yes, how many cigarettes per day? _____

I HAVE READ AND UNDERSTAND THE ABOVE AND HAVE COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE:

Signature: _____ Date: _____

Time 1:19 PM

Dental Health History Form

Date 9/12/2018

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Do you drink alcohol?	Yes No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	Yes No	If yes	
Do you use controlled substances?	Yes No	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed above?	Yes No	If yes	

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Great Mines Health Center

School Based Setting **DENTAL** Treatment Consent

Childs name: _____ Childs Birthdate: _____

Guardians name: _____

PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT

1. I hereby understand and authorize Great Mines Health Center providing dentist and/or assistants of their choice to perform upon my child/the patient named above, the following operation(s) and/or procedure(s) as deemed necessary by the treating dentist: Comprehensive dental care, not limited to, dental examination, x-rays, dental sealants, dental restorations (such as composite fillings, silver fillings, stainless steel crowns, pulpal therapies (treat the nerve inside the tooth), extraction of primary or baby teeth, orthodontic appliances, tooth cleaning and fluoride treatments. Only when necessary, the child's hands and head may be held still to limit disruptive movements to keep the child from injuring themselves or others while treatment is being completed. I understand that there are risks to dental treatment and when dental anesthetics are used including swelling, pain, allergic reaction, etc… If I would like further information about risks associated with dental treatment, please call (573)-438-8401 to speak with the dental staff or dentist.
2. If my child has high anxiety or is uncooperative and would require the use of nitrous oxide, sedation to receive dental treatment, or has other needs that cannot be met in the school dental clinic, I will need to schedule to be seen in the main dental clinic.
3. GMHC staff have fully explained to me the nature and purpose of the anticipated or planned treatment and has also informed me of expected benefits and complications (from known and unknown causes), advantages and disadvantages, attended discomforts and risks that may arise as well as possible alternatives to the proposed treatment, including no treatment. I have been given the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. I acknowledge that no guarantees or assurances have been made to me concerning the results of treatment.
4. I authorize Great Mines Health Center to use photographs, radiographs, treatment records, and other diagnostic materials for the purpose of teaching, research, and scientific publications with the assurance that my child's identity will remain confidential. If I decline consent to the use of records and photographs initial on this line; otherwise leave blank: _____

A dentist from Great Mines Health Center (GMHC) will be evaluating my child's dental condition. If my child requires treatment on multiple teeth, GMHC will do its best treat as many teeth in one appointment as possible. GMHC hopes to minimize your child's time away from class. However, it may take multiple appointments to treat multiple diseased teeth. In the process of dental treatment, if my child develops pain or oral infection I will contact GMHC's office at (573)-438-8401 for an appointment in the main office at #1 Southtowne Drive, Potosi, MO 63664.
Local anesthetics are administered for most dental treatment. After treatment my child may experience pain and swelling. There is a possibility that my child may bite the inside of his or her mouth or tongue before anesthesia wears off. My child will be instructed not to do so by GMHC staff.

I, _____ (guardians name) understand that I can be present at the school if I so choose while my child is receiving dental treatment. If I am not present I leave treatment decisions up to the dentist's professional judgment and experience. The dentist may change the treatment plan if it is deemed in his or her professional judgment to be in the best interest of my child. This signed consent authorizes treatment for my child's initial and future dental appointments. I understand that I am free to withdraw my consent to treat at any time in writing and that this consent will remain in effect until I choose to terminate it.

Parent or Guardian's Name (please print): _____

Your relationship to the child: _____

Parent or Guardians Signature: _____ Date: _____

Witness: _____ Date: _____

Dental Risk Assessment Form

Caries Risk Assessment Form

Patient Name:	
Birthdate:	Date:
Age:	Initials:

The following questions were developed by the American Dental Association to help evaluate the risk that your child has for the development of tooth decay. Accurate answers will help us provide the proper dental treatment for your child.

Contributing conditions to caries development or prevention (Parent section) **Please circle the answers that best applies to your child**				
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	YES	NO	
II.	**Sugary Foods or Drinks** (including juice, carbonated soft drinks, energy drinks, etc…)	Primarily at mealtimes		Frequent or prolonged exposure between meals
How many times a day does your child have snacks or sugary drinks between meals? 1, 2, 3, more than 3 times a day				
III.	**Caries or cavity Experience of Mother, Caregiver and/or other Siblings**	No cavities in the last 24 months	Cavities in the last 7 to 23 months	Cavities in the last 6 months
IV.	**Dental Home:** regularly sees a dentist for treatment	YES	NO	
V.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	NO		YES
VI.	**Chemo / Radiation Therapy**	NO		YES
VII.	**Eating Disorders**	NO	YES	
VIII.	**Drug / Alcohol abuse**	NO	YES	

Office use only below this line

Clinical Conditions (Circle all that apply)				
I.	Visual or radiographic evidence of restorations, cavitated or non-cavitated carious lesions	No new caries or restorations within 36 months	1 or 2 new carious lesions or restorations in the last 36 months	3 or more carious lesions or restorations in the last 36 months
II.	Missing teeth due to caries in the past 36 months	No		Yes
III.	Visible plaque	No	Yes	
IV.	Dental / Orthodontic Appliances present	No	Yes	
	Unusual tooth morphology that compromises oral hygiene	No	Yes	
	Interproximal restorations – 1 or more	No	Yes	
	Exposed root surfaces present	No	Yes	
	Restorations with overhands and or open margins; open contacts with food impaction	No	Yes	
	Xerostomia	No		Yes

Overall assessment of dental caries risk: Low Moderate High

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Great Mines Health Center (GMHC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Great Mines Health Center's Notice of Privacy Practices for more complete description of such uses and disclosures. I have the right to review your Notice of Privacy Practices prior to signing this consent. Great Mines Health Center reserves the right to revise its Notice of Privacy Practices at any time. A Revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager at 1 Southtowne Dr. Potosi, MO 63664. With my consent, the providers or designated staff may call my home or office or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care, including laboratory results among others. Also, I give my consent for Great Mines Health Center to send or receive my electronic prescription data, including electronic prescribing history, in regard to my medications to or from pharmacies and insurance companies, as needed, for proper continuation of my medical care or billing needs.

With my consent, Great Mines Health Center's designated staff may mail to my home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that Great Mines Health Center's designated staff restrict how they use or disclose my PHI to carry out TPO. However, Great Mines Health Center does, the practice is bound by our agreement.

By signing this form, I am consenting to Great Mines Health Center's use and disclosure of my PHI to carry out TPO. This consent may be revoked in writing except to the extent that Great Mines Health Center has already made disclosures in reliance upon my prior consent. If I decline to sign this consent, Great Mines Health Center may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Authorization of Disclosure of Protected Health Information

Patient Name:_____

Persons Authorized to Receive Information:

Health information that Great Mines Health Center collects or receives about me may be disclosed to the following persons:

_____ _____
Name of Person Relationship

_____ _____
Name of Person Relationship

Use and Disclosure of Information:

_____ I authorize the person(s) listed above to receive all health information about appointment, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare.
(please initial)

_____ I do not authorize the following information to be disclosed to any other parties except to me as the patient.
(please initial)

You may revoke or terminate this authorization by submitting a written revocation to Great Mines Health Center to the attention of Privacy Official or other authorized representative. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

If you have an answering machine, may we leave a messages regarding appointments, treatment, and/or information pertinent to your healthcare and/or payment for your healthcare provided at Great Mines Health Center.

_____ Yes _____ No

_____ I authorize, Great Mines Health Center, to release an excuse to my work/school.
(please initial)

Name of School or work_____

_____ I Authorize, Great Mines Health Center, to share my child's appointment schedule with,
(please initial)

_____(School District)

_____ _____
Signature of Patient/Parent or Legal Guardian Date

Great Mines Health Center
Sliding Fee Discount Application

The Sliding Fee Discount Program is a method for providing reduced fees, based on household size and income. In order to be qualified for this program, you must fill out the following application and provide our office with proof of income. Income examples are as follows: two recent paycheck stubs, recent tax return, Social Security Award letter, or Medicaid denial letter. Please know that your personal information on this form is used only by Great Mines Health Center.

Patient Name:_____ Date of Birth:_____Head of Household: YES or NO
(First Name, Last Name. Middle Initial)

Household Size:_____

Names of persons in Household ("Household;" is considered all people living at the same address):

_____

_____

_____

_____

Sources of Income for Household, "Monthly"

Salary/Wages:_____
Social Security Retirement:_____
Unemployment:_____
Child Support:_____
Public Assistance/Food Stamps:_____

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY!!!

I, the person who has signed below, have filled out this application for the Sliding Fee Discount consideration and can prove that this information is true and correct, to the best of my knowledge. I am also aware that if there is any change in financial status of any of the people in my household it must be report immediately to Great Mines Health Center, (GMHC) and a new application must be filled out. I understand that, upon request of GMHC, and yearly, there will be a review of my application with the chance of discount amount changes. I understand that any untrue information written on form or the failure to provide proof of income within 30 days may result in my being made not qualified for the Discount Fee reduced priced made available by GMHC. I also understand this discount service is for services provided within GMHC only!

Applicants Signature:_____Date:_____

As a Federally Qualified Health Care Center we are required to collect certain information. The information on this form is used to determine the amount of discount that you may receive from GMHC and/or for statistical purposes. I understand that my personal or financial information will not be released.

BELOW TO BE COMPLETED BY GMHC STAFF ONLY

Witness By (GMHC Representative):_____Date:_____
_____Approved_____% of discount approved_____Expiration Date:_____
Provision, if any_____
_____Disapproved Reason:_____
_____Pending Reason:_____
Certified By:_____Date:_____