



# HealthHUB School Clinic



Gifford Health Care

## Student Dental Enrollment Form

HealthHUB is a nonprofit organization with a mission to improve access to healthcare. Our Dental Hygiene trailer, in collaboration with Gifford Health Care, will be visiting your school. Services provided include dental cleanings, oral evaluation, necessary x-rays, fluoride treatments and sealants. Students are eligible if they have NOT had their teeth cleaned within the last 6 months.

Your dental insurance including Medicaid will be billed or you may self-pay. The fee schedule is posted on the HealthHUB website at [healthhubvt.org](http://healthhubvt.org), under the dental tab on the left. **Please complete both sides of this paper ENTIRELY and return it to the school secretary or nurse.**

We are pleased to provide dental hygiene services to adult family members as well as your children. Adults are asked to contact HealthHUB directly at (802) 431-6060 for an appointment.

**By signing this form and enrolling my child(ren) in HealthHUB's dental program, I consent to:**

- Treatment performed by the dental hygienist is limited in scope, according to the Vermont Statutes and Rules of dental hygiene scope of practice, and that it does not take the place of a regular dental examination or treatment by a licensed dentist.
- The dental hygienist works collaboratively with school nurses, your child's dentist and medical care provider with whom communication, records and x-rays may be shared and will be kept confidential. If your child does not have a dentist, a referral may be made with communication, records and x-rays shared in a confidential manner for your child's continuum of care.
- Dental records for services provided by the dental hygienist will be reviewed by a VT licensed dentist in which the dental hygienist holds a general supervising agreement.
- It is my responsibility to follow up with any treatment or examination, by a DENTIST, that the dental hygienist recommends for my child.
- It is my responsibility to pay HealthHUB for services rendered, if my child does not have Medicaid or private dental insurance. I also understand that I will pay any co-pays with private insurance.

***If you plan to enroll, please fill out the back of this page.***

**Yes, please enroll my child(ren) to receive dental hygiene care with HealthHUB.**

*(Includes up to 2 oral health screening and 2 cleanings within the year, fluoride and necessary x-rays)*

**Check if you would like preventative sealants placed on permanent molars, if needed.**

Child Name #1 \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Date of last dental cleaning \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Name of Medical Doctor \_\_\_\_\_ Health Concerns and Medications: \_\_\_\_\_

\_\_\_\_\_ Does your child need pre-medication before dental cleanings: Yes No

Child Name #2 \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Date of last dental cleaning and/or x-rays \_\_\_\_\_

Name of Medical Doctor \_\_\_\_\_ Health Concerns and Medications: \_\_\_\_\_

\_\_\_\_\_ Does your child need medication before dental cleanings: Yes No

**Dental Insurance Information - Please attach a copy of your insurance card.**

Insurance Company Name: \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_

Ins. Co. Address: \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

I will self-pay because my child(ren) does not have Medicaid or private dental insurance: YES NO

Parent/guardian \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ ZIP \_\_\_\_\_

Daytime phone (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

**Signature of parent/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I, \_\_\_\_\_, give my permission for HealthHUB to share my child's dental hygiene records with my child's dentist, school nurse and medical provider. If my child does not have a regular dentist, a referral may be made to a dentist which will include information about the dental hygiene visit. I have reviewed the HIPPA/Privacy policy.

**My child's dentist is:**

**The Health Center's Ronald McDonald Dental Van** YES NO

**Other dentist:** \_\_\_\_\_ YES NO

**Signature of parent/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If you have any questions, you may contact our dental hygienist, Janine, at [janine@healthhubvt.org](mailto:janine@healthhubvt.org) or leave a message at (802) 431-6060 ext 1.

Thank you for giving your child the opportunity  
to maintain a healthy, happy smile for a lifetime of wellness!