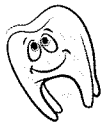


"CHOMPERS"

Northern Oswego County Health Services, Inc. (NOCHSI)
And
The Health Foundation for Western & Central New York

1. What is "CHOMPERS"?

This is a grant to provide dental cleanings, sealants, fluoride treatments and education to the students. This is a School Based Dental Program (SB-Dental Program)

2. Who can enroll?

All students located in the Fairgrieve Elementary Building.

3. What are the eligibility requirements?

Your child is attending school at Fairgrieve Elementary.
There are no financial requirements ***(All Insurances billed)***

4. How do I enroll my child?

You can find an enrollment form at the Fairgrieve Elementary School Office, Nurse's office or at nochsi.org

5. When are services provided?

Tuesdays from 8 am – 3 pm when school is open

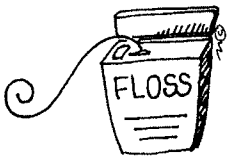
6. What if I have a dentist for my child?

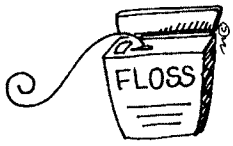
We can still provide cleanings, sealants, and fluoride treatments.

7. Do I need to be present for the appointment?

We always encourage parents/guardians to be present but not necessary. The Dental Hygienist will notify you after the appointment.

FOR ADDITIONAL QUESTIONS YOU CAN CONTACT NOCHSI DENTAL OFFICE AT





315-298-6815

Northern Oswego County Health Services, Inc.
Pulaski Health Center Dental

"CHOMPERS" Dental Program
Enrollment Form

Last Name	First Name	Middle	Date of Birth	Social Security Number	M F Sex
Parent/Guardian Last Name	First Name	Middle	Date of Birth	Social Security Number	Relationship
Parent/Guardian Last Name	First Name	Middle	Date of Birth	Social Security Number	Relationship

Street Address/PO Box	City	State	Zip Code

Contact Information:

Home Telephone Number	Emergency Contact Name	Emergency Contact's Telephone number	E-mail Address
Mom Work Number	Dad Work Number	Mom Cell Phone Number	Dad Cell Phone Number

Statistic Information for reporting purposes:
Race: □ Asian □ Native Hawaiian □ Pacific Islander □ Black/African American □ American Indian/Alaskan Native
□ White/Caucasian □ More than one race □ Refuse
Ethnicity: □ Hispanic/Latino □ Not Hispanic/Not Latino

Number of people in your household: _____ Annual House Hold Income: _____

Insurance Information: Please attach a copy of the insurance card. □ NO INSURANCE

□ Medicaid	Medicaid Number	Sequence Number	Please attach copy of card
Dental Insurance Name	Insured Name/Date of Birth	ID Number	Group Number
Insurance Address	Employer	Insurance Eligible Date	Please attach copy of card

Primary Health Care Information:

Primary Dentist Name	Address	Telephone Number
Primary Care Provider	Address	Telephone Number
Pharmacy	Address	Telephone Number

Does your child have medication allergies? □ No If yes please list: _____

Does your child have environmental allergies? □ No If yes please list: _____

What school does your child attend? _____

Do you have any dental concerns? _____

Northern Oswego County Health Services, Inc.
Pulaski Health Center Dental

"CHOMPERS" Dental Program
Enrollment Form

Patient First Name	Patient Last Name	Middle Initial	Date of Birth

Patient Medical History:

Does your child have any serious medical problems? □ Yes □ No

If "Yes" please list: _____

_____

Is your child taking any medications: □ Yes □ No

If "Yes" please list: _____

_____

Does your child have or had any of the following:

□ Diabetes	□ Bleeding problems	□ Convulsions or Fainting	□ Eye Problems
□ Kidney Problems	□ Heart Problems	□ Asthma	□ Nerve Problems
□ Broken Bones	□ Dental Problems	□ Pneumonia	□ Health Problems

□ Yes □ No Serious Accidents: _____

□ Yes □ No Operations/Surgery: _____

□ Yes □ No Hospital Visits – Overnight: _____

Other, please describe: _____

Behavior:

□ Yes □ No Does your child get along well in school? _____

Does your child suffer from any of the following:

□ Fussiness □ Holds Breath □ Thumb sucking □ Nail biting □ Overactive □ Slow Learner

□ Bad Temper □ Speech Problems □ Eats Dirt, Paint, or Glue

Other Explain: _____

Family History:

Has and family members had any of the following:

□ Diabetes □ Bleeding Disorder □ Cancer □ Recent Contagious Disease □ Heart Disease

□ Anemia □ Sickle Cell Anemia □ Asthma □ Low Blood Pressure □ Tuberculosis

□ Developmental Disabled □ Behavioral Health Issues

Other, please explain: _____

Dental History:

Date of last dental exam: _____ How often does your child brush their teeth? _____ Floss _____

What concerns do you have about your child's dental health? _____

□ Yes □ No Does your child ever have dental pain? If so, when? _____

□ Yes □ No Did your child have a negative dental experience? _____

□ Yes □ No Does your child smoke or use smokeless tobacco?

□ Yes □ No Has the child had orthodontic treatment?

□ Yes □ No Has the child had teeth removed?

□ Yes □ No Does your child have a "sweet" tooth?

□ Yes □ No How often does your child brush?

□ Yes □ No Has your child received any fluoride treatment? □ pills/vitamins □ topical □ water

□ Yes □ No Has anyone explained importance of primary teeth?

Thank you for participating in the "CHOMPERS" Program. Please complete the consent and attach a copy of the insurance card.

Parental Request for Dental Services and Authorization Release of Dental

Information to Process Insurance Claims

I hereby give my consent for my child to receive dental care services provided by the staff of the Northern Oswego County Health Services, Inc.'s Dental Office, including:

- Dental screening
- Fluoride treatments
- Prophylaxis (cleanings)
- Sealants
- Prescriptions when necessary
- Health education and counseling
- Referral to outside agencies (specialists, counselors, etc.) for services not provided

I authorize the release of necessary dental information to my designated insurance carrier for claims, and direct that any insurance payments be sent to Northern Oswego County Health Services, Inc.

If my child's Primary Care Provider (PCP)/Dentist are not affiliated with Northern Oswego County Health Services, Inc., I authorize the release of dental information to my child's Primary Care Provider/Primary Dentist unless otherwise specified.

I understand that every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State Law does not require parental consent for treatment of or advice regarding alcoholism, drug abuse, sexually transmitted diseases, pregnancy or contraception.

The staff of Northern Oswego County Health Services, Inc.'s Dental Office considers parental involvement very important. Accordingly, the staff will encourage every student to involve his or her parents or guardians in all counseling and dental care decisions.

Child's Name:	DOB:
Date of Last Dental Cleaning:	
Your name and relationship to the child:	
Signature:	Date:

Patient Consent Form rev. 07.15.2015

Northern Oswego County Health Services, Inc.

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical/dental or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare/dental services to you.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices before signing this Consent Form. By signing this consent form, you have acknowledged that you have received/been made aware of our ***Notice of Privacy Practices.***

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. ***We are not required to agree to any restrictions, but if we do, we are bound by our agreement.*** If you wish to make a restriction, please request a copy of our Form to Request Restriction.

If you do not sign this Consent Form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this.

Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

PRINT PATIENT
NAME:_____DOB:_____

PRINT PATIENT'S REPRESENTATIVE NAME and RELATIONSHIP:

_____

SIGNATURE OF PATIENT OR REPRESENTATIVE:_____

If minor, parent who has physical custody of minor: _____
I have the authority to give permission for treatment: ___yes ___no

I authorize _____to consent for treatment in my absence.
(Step-parent, grandparents, etc.)

DATE:_____ WITNESS SIGNATURE_____

Health Centers NOCHSI

Fulton • Mexico • Oswego • Parish • Phoenix • Pulaski

Health Centers			School Based Health Centers	
Fulton	(315) 598-4790	(315) 593-6195 Fax	Sandy Creek	(315) 387-3620
Mexico	(315) 963-4133	(315) 963-4960 Fax	Lura Sharp	(315) 298-2570
Oswego	(315) 342-0880	(315) 593-6195 Fax	Pulaski Middle/Sr. High	(315) 298-2696
Parish	(315) 625-4388	(315) 625-4535 Fax	APW Elementary	(315) 625-5210
Phoenix	(315) 695-4700	(315) 695-4706 Fax	APW Jr/Sr High	(315) 625-5213
Pulaski	(315) 298-6564	(315) 298-3968 Fax	Mexico Middle School	(315 963-8400 x4208

Dental Patients' Bill of Rights

As a dental patient in Northern Oswego County Health Services, Inc. – Dental Center in New York State you have the right, consistent with law, to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the dental health center MUST provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care during office hours if you need it.
5. Be informed of the name and position of the provider who will be in charge of your oral care in the dental health center.
6. Know the names, positions and functions of any dental health center staff involved in your care and refuse their treatment, examination or observation.
7. A no smoking facility
8. Receive complete information about your diagnosis, treatment and prognosis.
9. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. Refuse treatment and be told what effect this may have on your health.
11. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
12. Privacy while in the dental health center and confidentiality of all information and records regarding your care.
13. Participate in all decisions about your treatment from the dental health center.
14. Review your dental health record without charge. Obtain a copy of your dental health record for which the dental health center can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
15. Receive an itemized bill and explanation of all charges.
16. Complain without fear of reprisals about the care and services you are receiving and to have the dental health center respond to you and if you request it, a written response. If you are not satisfied with the response, you can complain to the New York State Health Department. The dental health center must provide you with the Health Department telephone number.

Northern Oswego County Health Services, Inc.
61 Delano Street, Pulaski, New York 13142-1400
(315) 298-6569 TDD: 711
www.nochsi.org
Serving the Community since 1969