Four Corners Youth Clinics

1301 Central Ave

Dolores, CO 81323

970-560-4890

Welcome Parents, Guardians and Students to a new school year!

Four Corners Youth Clinics has exciting news to share!

In addition to our medical services, we are excited to let you know that we will be providing dental services!

We have included all of our clinic forms in this packet.

Forms included are:

Dental Consent

Release of Information between the clinic and Dolores schools

Consent for treatment

Health History form

Oral Health Screening form

Please complete these forms to access our services.

The school will take the entire packet and forward it to the clinic.

I hope that everyone has a great school year!

Sincerely,

Rebecca Doughty

Rebecca Doughty, Program Director

Four Corners Youth Clinics

Four Corners Youth Clinics Dental Consent

1301 Central Ave
Dolores, CO 81323
970-560-4890

Students Name: _____ **DOB:**_____**Medicaid#**_____

CHP+/ Delta Dental #:_____

Parent Name: _____ **Phone:**_____

Mailing Address:_____ **City:** _____ **Zip Code:** _____

I give consent for my student to receive the following dental services from Four Corners Youth Clinics:

Please **CHECK MARK** services requested

□ Dental Screening	Free (Service provided by FCYC)
□ Oral Hygiene Education	Free (Service provided by FCYC)
□ Prophylaxis (Cleaning)	$35 (paid 100% by Medicaid and CHP+/ Delta Dental)
□ Fluoride Treatment	$25 (paid 100% by Medicaid and CHP+/ Delta Dental)
□ Silver Diamine(s) as needed	$35 each (paid 100% by Medicaid and CHP+/ Delta Dental)
□ Sealant(s) as needed	$35 each (paid 100% by Medicaid and CHP+/ Delta Dental)

REMEMBER MEDICAID AND DELTA DENTAL (CHP+) COVERS 100% ONLY IF IT HAS BEEN SIX MONTHS SINCE LAST DENTAL CLEANING.

PLEASE CHECK MARK PAYMENT METHOD

*□ Medicaid *□ CHP+ □Check **included** (payable to FCYC): $_____

Does your student have any health concerns to consider before these services are completed (**heart problems, allergies- latex/food/other, currently taking any medications, other serious health problems**)? **Please list:**

_____

_____

Is there any additional information about your student or comments you would like to mention before services are administered?

Please list: _____

Race: □ Native American/Alaskan □ Latino/Hispanic □ African American □ Asian

□ Caucasian □ Other: _____

Notice of Privacy Practices is available from FCYC: 1301 Central Ave Dolores CO 81323 **970-560-4890.** By signing below, I give consent for the above services and have had the opportunity to review a copy of this notice.

_____ _____

Please Sign (Parent/Guardian) **Date**

*MEDICAID AND CHP LIMIT THE NUMBER OF CLEANINGS AND FLUORIDE TREATMENTS ALLOWED PER YEAR. IF YOUR CHILD HAS RECEIVED THIS TREATMENT ***IN ANY OTHER OFFICE*** LESS THAN 6 MONTHS FROM THE DATE OF TREATMENT AT THE SCHOOL DENTAL PROGRAM, YOU MAY BE RESPONSIBLE FOR PAYMENT.

Rev 05/16

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Every Child Pediatrics (Medical Sponsor)
Four Corners Youth Clinics
Dolores, CO 81323

Phone: (970) 560-4890, Fax: (970) 564-1654

Patient Name: _____ DOB: _____

Name of Person(s) /Organization for exchange of information to and from:

Dolores School District RE-4A ←——————→ **Four Corners Youth Clinics**

Information to Be Released:

_____ Summary of Primary Care Record _____ Summary of Behavioral Health Care Record
_____ Consultations _____ Attendance _____ School records

Specific dates needed *(optional)*: _____

Reason for Disclosure:

____ Coordination of services _____Referral to service

I certify that this request has been made voluntarily and that the information given above is accurate. Disclosure of information between entities will follow minimum necessary guidelines. I understand that this consent may be revoked at any time, with the exception that disclosure of information has already occurred prior to the receipt of the revocation by the above-named provider. If written revocation is not received, the authorization will be considered valid for a period of time **not to exceed 1 year (365 days) from the date of signing.**

Individual Patient's signature: I have read and agreed with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the Protected Health Information described in this form with the people and/or organization named in this form.

Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Relationship to patient: _____

Student Signature:_____ Date:_____

Four Corners Youth Clinics

Every Child Pediatrics - MEDICAL SPONSOR

Services include: • Primary care •Urgent care • Physical exams • Immunizations • Dental Clinics • Behavioral health services

Patient Name: _____ **Date of Birth:** _____ **Sex: M / F**

School Attending: _____ **Grade Level:** _____ **Patient Cell Phone #** _____

Permission to Call/Text: Yes / No

Race/Ethnicity *(circle all that apply)*: Hispanic Asian Black White Native American Hawaiian/ Pac. Island 2 or more races

Preferred language (circle) English Hispanic Native American Asian Other: _____

Address: _____ **Zip** _____

Parent/Guardian Name: _____ **Phone #:** _____

Permission to Call/Text: Y / N

Health Insurance *(circle)*: None Private Medicaid CHP+ IHS Sliding Scale

Insurance CO: _____ ID# _____

Primary Provider: _____

MUST SHOW INSURANCE CARD AT TIME OF VISIT OR SIGN ATTESTATION FORM FOR SLIDING SCALE

Consent for Treatment - Parental/Guardian, Emancipated Minor, Adult Student

Parental Consent: I understand that my child may be seen at Four Corners Youth Clinics (FCYC) only with my consent if under 18 years of age or not emancipated, or able to provide minor consent in accordance with Colorado state law, and that this consent will remain in force through the age of 21 or until I revoke said consent in writing. It is my responsibility to notify the clinic about changes in guardianship or insurance. The only exceptions to this policy are: a student may be seen one time to discuss the need for services; services will be provided in case of any emergency.

Release of Information: Four Corners Youth Clinics is a HIPAA compliant health center. Information in my child's healthcare record is confidential and will not be released to any unauthorized person or agency without written consent. In conformance with Colorado law guiding all medical facilities, my son/daughter may request that visits and health information remain confidential, under some circumstances. For me or any other party to have access to healthcare records regarding such information, my child must complete a written release.

Data Sharing Information: I understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for health services I/my child receives at this school-based health center, and is legally able to receive information regarding services provided to patients. CDPHE receives combined data for all patients, and this data does not specifically identify any individual patient.

Coordination of Care/Billing: I authorize FCYC to disclose all or any portion of my child's healthcare record to any person or entity performing record keeping or billing services for the Four Corners Youth Clinics and any person or entities performing billing on behalf of Four Corners Youth Clinics. I also authorize the staff of FCYC to disclose all or any portion of my child's medical record to persons or entities pertinent to his/her health care, including the primary care provider listed on this form, school health paraprofessionals, Every Child Pediatrics staff, the Food Service Director, and the Montezuma County Public Health Department in order to best provide for the health and safety of my child. I understand that if my child is scheduled for an overnight school trip, basic medical information such as allergies, immunization status, and current meds may be shared with the supervising teacher to provide for a safe and healthy environment during the trip. I also give consent to access my child's school immunization information and for it to be entered into the Colorado Immunization Information System (CIIS).

I give my consent for the named patient to receive necessary and/or advisable health services from the staff of FCYC.

I acknowledge receipt of the Notice of Privacy Practices and Patient Bill of Rights and Responsibilities: ☐

SIGNATURE of patient: _____ Date _____

PRINTED name of parent/guardian, emancipated minor, or adult student: _____

SIGNATURE of parent/guardian, emancipated minor, or adult student: _____ DATE _____

Four Corners Youth Clinics History Form

Name:_____Date of Birth_____ Gender:_____

Current Medications: ☐ None /_____

Any allergies (medications/food/insects): ☐ None /_____

Have you ever had or experienced *(Circle all that apply):*

Arthritis Asthma Anemia Diabetes Eye injury Head Injury or Concussion Heart Problems/Murmi

High Blood Pressure Kawasaki Disease Mono Sickle Cell Seizure Skin rash or infections Stress fractur

Broken bone Dislocated joint Xray Torn ligament/tendon MRI/CAT Scan Bulge or pain in groin area

Surgery Spent night in hospital Wear glasses/contacts

At birth, were you born: Premature Missing any organs Heart problems/surgery as a baby

When you exercise, have you ever:
Passed out or nearly passed out? Y / N
Had any discomfort, pain, heaviness or tightness in your chest? Y / N
Cough, wheeze, or have difficulty breathing during or after exercise? Y / N
Felt your heart race or skip beats? Y / N
Get more short of breath than expected? Y / N
Have any joints that become red, swollen, or painful? Y / N
Any bones, muscles, or joints that bother you? Y / N
Have you ever used an inhaler? Y / N
Had headaches? Y / N
Had numbness, tingling, or weakness in arms or legs? Y / N
Become ill when exercising in the heat? Y / N
Regularly use a brace or other device? Y / N

Do you worry about your weight? Y / N If yes, are you wanting to: Gain / Lose weight
Any special diet or foods you avoid? _____

Girls: Have you ever had a menstrual period: Y / N. How old were you when you started?_____

Family History: Does anyone in ***your family*** have (Circle): High Blood Pressure Severe allergies Asthma

Sickle Cell Cancer Diabetes Seizures Heart Problems

Additional comments:_____

_____

Provider reviewed with patient on date _____ Signature _____

ORAL HEALTH SCREENING FORM

Your child's oral health is important. In other school years, preventive dental services have been offered to children in schools, but that is on hold this year due to COVID-19. We are asking parents to complete this short screening form so that your child can be connected to dental care if needed. Please complete this form and return it to your child's school.

Cavities are the most common disease of childhood, and cavities can often grow unnoticed. Children who have cavities or tooth pain might talk about it in different ways. A child might mention pain when they eat, sleep, or try to concentrate. The following questions are other ways to see if they have pain in their mouths.

Does your child say that their teeth or jaw hurt?	Yes ___	No ___
Can your child chew hard foods *(carrots, crunchy snacks, etc.)* using both sides of their mouth?	Yes ___	No ___
Do your child's gums bleed when they brush their teeth?	Yes ___	No ___
Does your child say that cold or hot foods bother their teeth?	Yes ___	No ___

Cavities can start in your child's mouth without them knowing, so it's important to look inside their mouth. Taking a look about once a month is helpful if they are not able to visit a dentist for regular check-ups. When looking in their mouth, it's best to use a flashlight and look at all surfaces of their mouth. This means looking at the gums, the teeth, under the tongue, on the inside of the cheek, and on the roof of the mouth.

___ Swelling on the gums	___ White spots on the gum line or tooth surface	___ Cavities or dark spots on any tooth surface
___ Active bleeding	___ Broken teeth	___ Rashes or discoloration of the roof of the mouth

Has your child had a dental appointment in the last year?	Yes ___	No ___
Do you plan to take your child to a dental check-up? *(please see page 2 for what this includes)*	Yes ___	No ___
Do you need help locating a dental provider?	Yes ___	No ___
Do you have dental insurance?	Yes ___	No ___
If no, would you like help finding insurance?	Yes ___	No ___

Has your child received a fluoride varnish application from a dental provider or medical provider within the last year? *(see page 2 for definition of fluoride varnish)*	Yes ___	No ___
Has your child received a sealant on any of their permanent molars from a dental provider? *(see page 2 for more information about a sealant)*	Yes ___	No ___

If you see anything concerning, contact your dental office or use the contact information provided with this form.

COLORADO
Department of Public Health & Environment

ORAL HEALTH SCREENING FORM

What is a dental check-up?
A dental check-up for a child includes a dental provider looking in the mouth, taking x-rays, and cleaning the teeth. It may include applying sealants and fluoride varnish to prevent cavities.

What is fluoride varnish?
Fluoride varnish is a sticky gel that is painted on the teeth to prevent cavities, slow them down, or stop them from getting worse. Fluoride varnish is made with fluoride, a mineral that strengthens tooth enamel (the outer coating on teeth).

What is a sealant?
Dental sealants are thin coatings that when painted on the top of the back teeth (molars) can prevent cavities (tooth decay) for many years. Sealants protect the tooth from cavities by covering them with a protective coating that blocks out germs and food.

Thank you for completing this screening form. _____ has your permission to contact you for any follow-up dental care needs.

Yes ___ No ___

Please provide your contact information below.

Child name: _____

Guardian name: _____

Guardian signature: _____

Phone number: _____

Remember to:
- Brush twice a day, for two minutes. If your child is young, make sure to assist them and model good brushing habits.
- Don't share your toothbrush.
- Change your toothbrush after you've been sick.
- Look in your child's mouth to identify any swelling, bleeding gums, or broken teeth, and call a dental office in your community if you see urgent dental needs.

For more information about your child's oral health please visit the following websites:
https://www.mouthhealthy.org/en/babies-and-kids
https://www.aapd.org/resources/parent/

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