Regional Primary Care Network
Community Dentistry Program

If you have questions regarding CDP, please call **(585) 243-7847**. We look forward to visiting your child's school.

RPCN Administration
259 Monroe Avenue
Lower Level
Rochester, NY 14607
585-325-2280
585-325-2293 (fax)
rpcn.org

Livingston CHC
1 Murray Hill Drive
Building 1, Room 140
Mt. Morris, NY 14510
585-243-7840
585-335-1751
585-243-7841 (fax)

Rushville CHC
2 Rubin Drive
Rushville, NY 14544
585-554-4400
315-279-6705
585-554-4402 (fax)
585-554-3342 (HIPAA fax)

Mohawk Valley Administration
3 Parkside Court
Building 2
Utica, NY 13501
315-793-7600 x7500
315-738-2994 (fax)

Utica CHC
1651 Oneida Street
Utica, NY 13501
315-793-7600
315-792-0080 (fax)
315-792-0079 (HIPAA fax)

Wayne CHC
1519 Nye Road
Lyons, NY 14489
315-871-3178
315-946-6838 (fax)

Dear Parent/Guardian: Register Your Child Today!

The Community Dentistry Program (CDP) is **educational, convenient and affordable** and will be visiting your child's school in the coming weeks.

The program provides students who enroll with **FREE** dental screening, toothbrush, dental floss and **FREE** oral health education. The dental staff will teach the students how to care for their teeth.

You are welcome to accompany your child during their CDP visit; however, we can provide the dental care without you being present.

If your child does not have a dentist, our expert staff at the Livingston Community Health Center can provide quality dental care to him/her. If your child does have a dentist, they may still participate in CDP. Our staff will work directly with your child's dentist to make sure they are aware of the services we provided.

In addition to the free education and dental screening, CDP staff offer the following services:

- Dental Exams performed by a Dentist
- Dental Cleanings to help prevent dental problems like cavities and gum disease
- Fluoride Treatments as needed; fluoride is applied to teeth to help prevent tooth decay
- Dental Sealants are a coating that is placed on the chewing surface of the permanent molars to help protect them from decay

If your child has dental insurance, the insurance carrier will be billed for these services described above. If you do not have dental insurance or cannot afford dental care, we have a sliding fee program to assist you. Our goal is to provide dental services to all regardless of ability to pay.

☐ **YES**, I want my child to participate.

To sign your child/children up for CDP services, please complete the attached paperwork and return it to your child's teacher in the enclosed envelope as soon as possible. Please seal the envelope to keep the information private.

☐ **NO**, I do not want my child to participate.

If you are **NOT** interested in the services, **please return the entire packet** to avoid further communication.

Child's Name: _____ Grade: ____ Teacher: _____

Parent/Legal Guardian Signature: _____

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SECTION I – STUDENT INFORMATION

Student's Name _____ Date of Birth __ __/__ __ /__ __ __ __

Social Security Number: __ __ __-__ __ - __ __ __ __

Address: _____ City _____State _____ Zip _____

School: _____Grade: _____Teacher:_____

***Please answer questions below by checking the box*:**

Student's Gender: ☐ Male ☐ Female
Race: ☐White/Caucasian ☐Black/African American ☐ Asian ☐Native American ☐ Native Hawaiian ☐Other Pacific Islander ☐More than one race
Ethnicity: ☐ Non-Hispanic ☐Hispanic

Student's primary **language** is: _____ Does the student need an interpreter? ☐ Yes ☐ No

SECTION 2 – DENTAL CARE

Does your child have a dentist? ☐Yes ☐No

If yes: Dentist's Name: _____ Phone # (_____) _____-_____

Street Address:_____City_____ State_____ Zip_____

Has your child had a dental exam in the past 6 months? ☐Yes ☐No ☐Unsure Cleaning? ☐Yes ☐No ☐Unsure

What is the source of your child's water? ☐ Well ☐ Town/City ☐ Bottled

Do you have any concerns regarding your child's dental health? ☐Yes ☐No If yes, please explain:
_____
_____

Please note: Your child's dentist **will be notified of the dental services provided through his/her participation in CDP.*

SECTION 3 – PROGRAM PARTICIPATION: Please **choose one** of the following options below

Option1

☐ **YES,** I do wish for my child to participate in the program **(Please complete all 4 pages of the registration form)**
☐ I would like to accompany my child to his/her visits; please contact me at (_____)_____-_____(phone) to arrange an appointment time.

Option 2

☐ **NO**, I do not wish for my child to participate in the program.
If you do not want your child to participate, please sign below. Do not continue to complete this form but return in the attached envelope.

Signature: _____ Print Name: _____ Date: _____

If you require assistance with completion of this form or have any questions, please call **585-243-7847**

SECTION 4 – PARENT/GUARDIAN INFORMATION and RESPONSIBLE PARTY

Mother's Name: _____ Phone # (____)-_____(h) (____)-_____c) (____)-_____ (w)
Email: _____
Father's Name: _____ Phone # (____)-_____(h) (____)-_____c) (____)-_____ (w)
Email: _____
Guardian's Name: _____ Phone # (____)-_____(h) (____)-_____c) (____)-_____ (w)
Email: _____

Emergency Contact:
Name: _____Relationship to child: _____
Phone # (_____) _____-_____ (h) (_____) _____-_____(c) (_____) _____-_____ (w)
Street Address: _____City: _____ State: _____ Zip: _____

SECTION 5 – FINANCIAL

In order for RPCN to help patients without insurance coverage we must ask you to complete the following information. This is requested of you so that RPCN can receive Federal grant dollars to serve those patients. We appreciate your cooperation. All information is kept confidential and is used for reporting purposes only.

Total Number of people in your household (include everyone): _____

Total Household income: (*Please check the amount that best describes the total income in your household)*

☐ Less than $11,000	☐ $30,001-$35,000	☐ $$55,001-$60,000
☐ $11,001- $15,000	☐ $35,001- $40,000	☐ $60,001-$65,000
☐ $15,001- $20,000	☐ $40,001- $45,000	☐ $65,001- $70,000
☐ $20,001- $25,000	☐ $45,001- $50,000	☐ $70,001- $75,000
☐ $25,001-$30,000	☐ $50,001 - $55,000	☐ Greater than $75,001

Financial Assistance: *Based on the information in household income above, you and your family may be eligible for RPCN's Sliding FEE Scale Discount Program. A staff member may be contacting you for follow-up.*

Dental Insurance Information

Responsible Party: (This is the individual who is responsible for the payment of your child's bills)
Name: _____Date of Birth __ __/__ __/__ __ __ __ Social Security Number__ __ __-__ __ - __ __ __ __
Mailing Address: _____City: _____State: _____ Zip Code: _____
Phone Number: (_____) _____-_____ Relationship to Child _____

☐ **NO** my child **DOES NOT** have **dental** insurance
☐ **YES** my child **HAS dental** insurance (This information can be found on the **dental** insurance card that covers your child)

Dental Insurance Name: _____ Subscriber/Enrollee ID: _____ (number is on the card)

Group Number: _____ Group Name: _____

Insurance Company Street Address: _____ City_____ State_____ Zip_____

Name of person who carries the insurance: _____ Date of Birth __ __/__ __/__ __ __ __ Relationship to patient: _____

Please complete this section if your child has more than one type of dental insurance:

Dental Insurance Name: _____ Subscriber/Enrollee ID: _____ (number is on the card)

Group Number: _____ Group Name: _____

Insurance Company Street Address: _____ City_____ State_____ Zip_____

Name of person who carries the insurance: _____Date of Birth __ __/__ __/__ __ __ __ Relationship to patient: _____

SECTION 6 – SERVICES: (Current School Year Only)

Students enrolled in this program will receive **free education and a dental screening.**

Please check the additional services you are choosing for your child:

☐ **Cleaning** (May be up to 2 times per school year), **with fluoride treatment**, by a hygienist followed by an **exam** by a dentist.
☐ **Cleaning** (May be up to 2 times per school year), **without fluoride treatment**, by a hygienist followed by an **exam** by a dentist.
☐ **Fluoride treatment may be every 3 months** (Ages 6 years and younger.)
☐ **Sealants** (A coating that protects teeth from cavities)

SECTION 7 – MEDICAL HISTORY

Health History Information: Please ***check*** any of the following conditions your child has had, either currently or previously:

☐ ADHD/ADD
☐Allergy to Latex ☐ Blood Disorder/Anemia ☐Low/High blood Pressure
☐Cancer ☐Pregnancy (Due Date: _____) ☐Diabetes
☐Asthma ☐Seizures or Epilepsy ☐Tuberculosis (TB)
☐Kidney disease or Trouble ☐ Heart Trouble (including murmur, prosthesis)
☐Allergy to Medication(s) List: _____
☐Other Allergies: _____
☐Other: _____
☐ None of the Above

If yes to any question above, please explain: _____
List any major surgeries (types & dates): _____
List the reason for any overnight hospitalizations in past 3 years: _____

Current Treatments/Medications:

Is your child currently being treated by his/her medical provider for any reason? ☐Yes ☐No

If yes, explain: _____

Is your child taking any medication? (Including vitamins and/or fluoride) ☐Yes ☐No

If yes, please list medications:
_____

Medical Provider Information:

Does your child have a Medical Provider (Doctor, Nurse Practitioner, Physician Assistant)? ☐Yes ☐No

If Yes, Name of Provider: _____

Address: _____ City _____State _____ Zip _____

Phone # (_____) _____-_____

Pharmacy Information:

Name of pharmacy: _____

Address/Location: _____ City: _____

SECTION 8 - CONSENT

(**In order for us to treat your child, you must sign below indicating you have read and agree to the following information**):

Authorization for Treatment:

I, the undersigned, the parent or legal guardian of the above named child, hereby authorize the dental staff of RPCN, Inc. to provide dental care as indicated to my child in his/her school.

Financial Responsibility/Assignment of Benefits:

I authorize RPCN, Inc. to apply for benefits on my behalf to my child's insurance carrier and request my child's insurance company pay directly to RPCN, Inc. insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify RPCN of any changes. ***If your child has had a dental cleaning within the past 6 months and you have used your insurance, he/she is not eligible for insurance reimbursement at this time.*** If your insurance covers partial payment or denies services you may be billed for services. The following services and fees may be billable: dental cleaning with a fluoride treatment is $73.00 (ages 0-11), dental cleaning with a fluoride treatment is $90.00 (ages 12+), fluoride treatment is $21.00, initial dental exam is $48.00, recall patient exam is $28.00 and sealants are $35.00 per tooth.

Release of Information:

I consent to having my child's doctor release my child's medical information to the RPCN dental staff, if my child's health history indicates health problems which may affect his/her dental treatment.
If a dentist is noted above, I understand that any dental findings/treatment shall be forwarded to that provider.

****Forms that do not have a parent/guardian's signature will be returned****

Parent/Guardian Signature: _____PrintName:_____Date:_____

FOR OFFICE USE ONLY

☐ Insurance Verified _____ (date)

☐ Patient Registered Chart #:_____

☐ Primary Dentist was called and date of last services verified ☐ Yes (Add dates below) ☐No

Prophy: _____ If **no**, list reason: _____

Fluoride: _____ _____

Exam: _____ _____

Other: _____

DATE	Correspondence/ Missing Information	Initials

If you require assistance with completion of this form or have any questions, please call **585-243-7847**