AltaMed School Based Dental & Behavioral Health Services Enrollment Form

Please fill out and submit completed form to School's Main Office.
An AltaMed School Based Program staff member will reach out once form is received.

I give my child permission to obtain BEHAVIORAL HEALTH/COUNSELING SERVICES while enrolled in a school serviced by AltaMed or until I revoke permission. ☐ YES ☐ NO

All insurances will be billed at the time of the visit with no out-of-pocket fees or co-payments.

I give my child permission to obtain ON-SITE/MOBILE DENTAL SERVICES while enrolled in a school serviced by AltaMed or until I revoke permission. ☐ YES ☐ NO

For patients enrolled in Medi-Cal Dental, services are 100% covered with no additional fees or charges.
For patients without Medi-Cal Dental, problem focused exam can be rendered.
RISKS: Although infrequent, some discomfort and soreness may occur with dental procedures.

I certify that the health information provided is accurate to the best of my knowledge and understand that incorrect information can be dangerous to the student/patient's health. I will notify AltaMed of any changes to medical information. ☐ YES ☐ NO

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

I authorize the release of any medical, dental or behavioral health information necessary to process my claim. I also authorize payment of health benefits to AltaMed for services provided. ☐ YES ☐ NO

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that information regarding how AltaMed will use and disclose my information can be found in AltaMed's Notice of Privacy Practices. A copy of the Notice of Privacy Practices can be viewed at www.AltaMed.org/regulatory-notices. In addition to the uses and disclosures detailed in the Notice of Privacy Practices, I agree to permit AltaMed to send text messages to my child (only for scheduling purposes) or to me if a cell phone number(s) is listed below. ☐ YES ☐ NO

AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION

I hereby authorize AltaMed to exchange health and education records with my child's school district for the purpose of providing care and treatment to my child, if applicable, and/or to exchange dental exam information. I recognize that health records if received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by Family Education Rights & Privacy Act. ☐ YES ☐ NO

Student/Patient Information

Student/Patient Full Legal Name | Date of Birth | Sex

Social Security Number | Primary Language | ◯ Hispanic ◯ Non- Hispanic Ethnicity

◯ American Indian ◯ Asian ◯ Black ◯ Hispanic/ Latino ◯ Native Hawaiian ◯ White ◯ Unknown Other
Race

Street Address | Apt/Unit | City | Zip Code

Student/Patient Phone Number | Student/Patient Email Address

School Name | Grade

◯ Yes ◯ No
Does the patient qualify for free/reduced lunch?

◯ Yes ◯ No
Does the student/patient have a dentist?

Dentist's Name and Office | Dentist's Phone Number

Dental: (323) 558-7610
Behavioral Health: (855) 425-1777

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Parent/Legal Guardian Information

Parent/Legal Guardian Full Legal Name | Relationship to student | Date of birth

Stress Address (if different from above) | Apt/Unit | City | Zip Code

Parent/Legal Guardian's Phone Number | Parent/Legal Guardian's Email Address

Messages can be left for me on: ◯ Home phone ◯ Cell phone ◯ Work phone

Parent/Legal Guardian's Primary Language

Emergency Contact (If different from Parent/Legal Guardian)

Full Legal Name | Relationship to student | Phone number

Signature of Parent/Legal Guardian or Student if over 18 years old

Print Full Legal Name | Date | Signature

By signing above, I understand and acknowledge that I have read and understand this consent.
I can review AltaMed's Notice of Privacy Practices currently in effect at **www.AltaMed.org/regulatory-notices**.

Student/Patient Insurance Information

Health/Dental Insurance Name | Subscriber ID

Student/Patient Medical History

For Dental, medical history will need to be updated every four years

Student/Patient Full Legal Name | Date of birth

Student/Patient Medical History

Does the patient have any medical conditions?	☐ YES ☐ NO	Explain:
Does the patient take any medications? (including inhalers)	☐ YES ☐ NO	List medications:
Has the patient had any serious injuries?	☐ YES ☐ NO	Explain:
Does the patient have a birth or heart defect or have history of a heart problem or surgery?	☐ YES ☐ NO	Explain:
Has the patient had surgery in the past?	☐ YES ☐ NO	Explain:
Is the patient pregnant or possibly pregnant?	☐ YES ☐ NO	Due date:
Is premedication with antibiotics needed prior to dental procedures?	☐ YES ☐ NO	Explain:
Does the patient smoke, vape, or chew tobacco?	☐ YES ☐ NO	Explain:

Does the student/patient have or had any of these problems?

Anemia/blood disorders	☐ YES ☐ NO	Pneumonia	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Rheumatic fever, heart disease, murmur	☐ YES ☐ NO
Autism	☐ YES ☐ NO	Scoliosis	☐ YES ☐ NO
Bladder or kidney infections	☐ YES ☐ NO	Seizures	☐ YES ☐ NO
Cancer/leukemia	☐ YES ☐ NO	Thyroid disease	☐ YES ☐ NO
Chicken pox	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Ulcer/digestive problem	☐ YES ☐ NO
Eating issues	☐ YES ☐ NO	Any mental health issues?	☐ YES ☐ NO
Endocrine/gland disease/autoimmune disease	☐ YES ☐ NO	Any birth or congenital defects?	☐ YES ☐ NO
Headaches/migraines	☐ YES ☐ NO	Any problems with teeth?	☐ YES ☐ NO
Hepatitis or liver problems	☐ YES ☐ NO	Any teeth causing pain?	☐ YES ☐ NO
Learning/developmental issues	☐ YES ☐ NO	Any bleeding when brushing or flossing?	☐ YES ☐ NO
Herpes	☐ YES ☐ NO	Had a dental cleaning within the last 6 months?	☐ YES ☐ NO
Overweight/obesity	☐ YES ☐ NO	Others not listed. If other list conditions:	

Allergies

Any foods	☐ YES ☐ NO	Comment:
Any medications (including over the counter or antibiotics; penicillin or amoxicillin)	☐ YES ☐ NO	Comment:
Latex	☐ YES ☐ NO	Comment:
Does the patient have an Epi-Pen at school?	☐ YES ☐ NO	Comment:
Other:		Comment:

Behavioral Health (Please complete ONLY if student/patient is in need of counseling services)

Would you like to enroll the patient in behavioral health services? ☐ YES ☐ NO

Has the patient ever had counseling services?	☐ YES ☐ NO	If yes, when and with whom?
Has the patient been hospitalized for psychiatric emergency?	☐ YES ☐ NO	If yes, when?

Has the patient have or had any of the following concerns?

Family changes	☐ YES ☐ NO	Truancy/school avoidance	☐ YES ☐ NO
Social/peer stresses	☐ YES ☐ NO	Grief/Recent Loss	☐ YES ☐ NO
Anxiety	☐ YES ☐ NO	Drugs or alcohol use	☐ YES ☐ NO
Anger issues	☐ YES ☐ NO	Self-esteem issues	☐ YES ☐ NO
Attention difficulties	☐ YES ☐ NO	Gender identity issues	☐ YES ☐ NO
Sadness and/or mood swings	☐ YES ☐ NO		

If answered yes to any of the above, please explain: