River Valley Health
Where Care Meets Compassion

Dental School Program Enrollment Form
(PLEASE PRINT)

Patient's Last Name:_____First Name:_____MI: _____

Sex:_____Date of Birth:_____Social Security #:_____

Address (Include Apt. #):_____City: _____State:_____

Zip Code: _____Pharmacy: _____School Child Attends:_____Grade_____

# of Persons in Household:_____Monthly Household Income: _____

DENTAL INSURANCE CARRIER:_____POLICY NUMBER:_____

Gender Identity:
- ☐ Male ☐ Female
- ☐ Neither Exclusively Male nor Female
- ☐ F to M/Transgender Male/Trans Man
- ☐ M to F/Transgender Female/Trans Woman
- ☐ Refused to Report
- ☐ Other_____

Sexual Orientation:
- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Lesbian/Gay/Homosexual
- ☐ Unknown Refused to Report

Housing Status:
- ☐ Not Homeless
- ☐ Doubling Up
- ☐ Homeless Shelter
- ☐ Public Housing
- ☐ Street
- ☐ Transitional

Race:
- ☐ White
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ American Indian/Alaska Native
- ☐ Other Pacific Islander
- ☐ Declined to Answer

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Declined to Answer

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Chinese
- ☐ German
- ☐ Italian
- ☐ Japanese
- ☐ Other
- ☐ Sign Language

MEDICAL HISTORY: (Please attach additional sheet if needed)

Surgeries/Hospitalizations: _____

Illnesses:_____

Medications:_____

Allergies: _____

Primary Care Provider:_____Date of Last Visit:_____

PARENT/GUARDIAN CONTACT INFORMATION:

NAME: _____

PHONE:_____SECONDARY PHONE: _____

EMAIL ADDRESS: _____

Parent/Legal Guardian Signature: _____ **Date:**_____

United Way Lycoming County United Way

This program is funded in part by the Lycoming County United Way.

Dental School Program
Consent for Treatment

Patient (Child's) Name: _____ Date of Birth: _____

This authorization and consent is intended to cover the delivery of dental care services to my minor child (referenced above) by River Valley Health.

- I understand that this authorization will remain in effect with no expiration, unless revoked. I may revoke this authorization at any time, following the procedures outlined in the River Valley Health **Notice of Privacy Practices**.
- I understand that by signing this authorization, I am giving River Valley Health the authority to provide treatment, including administration of medication, as necessary in the provider's judgment.
- I understand that the practice of medicine is not an exact science, and no person has made a guarantee about the outcome of such care.
- I reserve the right to refuse specific treatment at any time.

By signing below, I hereby consent to treatment by all River Valley Health providers, staff and others that may be involved in the dental care of my child in ways they judge are beneficial, to include but not limited to dental exams, dental cleanings, dental x-rays, fluoride varnish, restorative care, sealants, and silver diamine fluoride (a topical fluoride used to treat and prevent dental caries and relieve tooth sensitivity which will stain/discolor the caries brown or black). Further, I understand that such treatment may be provided outside of my physical presence by signing this consent.

I understand I have full access to the following documents at any time online at www.rivervalleyhealthpa.org:

- River Valley Health Notice of Privacy Practices
- Patient Rights and Responsibilities

At any time, I can request a hard copy of these documents by calling River Valley Health.

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

Parent/Legal Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____

River Valley Health Williamsport Medical and Dental
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