Appendix A – Supporting Documents

Parent Permission Form – English

Parent Permission Form – Spanish

Permission for treatment – English

Permission for treatment – Spanish

Dental Screening permission form

Dental Screening results

Integrated Health Services brochure

Referral list

Referral form – East Hartford Orthodontics, LLC

Referral form – Care Endodontics

Referral form – Oral Facial Surgery Center

Sterilization log

INTEGRATED HEALTH SERVICES, INC.

School Based Health Center Program
Offering: Medical Care, Dental Care, and Behavioral Health Counseling Services

www.Integratedhealthservices.org

Grade: _____
School: _____
Date: _____

PARENTAL/GUARDIAN PERMISSION FORM CONCERNING TREATMENT

This form concerns treatment your child can receive through the School Based Health Center (SBHC) operated by Integrated Health Services, Inc (IHS). IHS's services are described in the brochure "Your School Based Health Center". If your child is under 18 years of age, IHS cannot provide SBHC services until you have read the brochure, sign and date this permission form and the HIPPA form and return the forms to the SBHC at your child's respective school.

Student Information: Please Print

Student's Name: _____ Sex: ☐ Female ☐ Male
(Last) (First) (Middle)

Address: _____ City: _____ Zip Code: _____

Birth Date: _____ Home Phone: _____ Social Security No. _____

Race: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American/Haitian
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Parent/Guardian Information:

Name: _____ Home #: _____ Cell Phone #: _____

E-mail Address: _____ Work #: _____

Relationship to student: ☐ Parent ☐ Guardian ☐ Other _____

Number of people living in household: _____ Combined yearly household income: $_____

Student Insurance Information: Please select all that applies

1. **Medicaid/Husky**: Childs Medicaid #_____

2. **Private Insurance Carrier Information:**
   Insurance Co. Name _____ Policy #: _____ Group #: _____
   Employee Name: _____ Employer Name: _____
   Employee DOB: _____ Relationship to Child: _____

3. **My Child <u>does not</u> have any insurance coverage:** _____ Please give reason: _____

DENTAL Insurance Information:

A) Insurance Company Name: _____ Policy #: _____
B) ☐ My Child Does Not Have Any Dental Insurance

Primary Source of Medical Care Information:

Primary Care Doctor Name: _____ Phone #: _____

No Primary Care Doctor, Child Gets Medical Care From:
☐ School Based Health Center ☐ Hospital/Clinic ☐ Military Clinic ☐ Emergency Room
☐ Community Health Center ☐ Urgent Care Center ☐ No Regular Source ☐ Private Doctor

Student Name: _____ **DOB:** _____ **Grade:** _____

Student Medical History:

Current Medications: (*Please list all medications presently being taken including any over the counter meds*)

_____

Medication Allergies: _____ Other Allergies: _____

Age of First Menstrual Period: _____ Accidents: _____

Hospitalizations: _____ Surgeries: _____

Injuries: _____ Other Illnesses-Please Specify: _____

Overdoses/Poisonings: _____ _____

Please √ any problem the STUDENT has or had:

YES/ NO	YES/NO	YES/NO	YES/NO
___/___ Addiction to Drugs/Alcohol	___/___ Emotional Issues	___/___ High Blood Pressure	___/___ Rheumatic Fever
___/___ Allergies	___/___ Eye Problems- glasses	___/___ Joint Pain	___/___ Skin Problems
___/___ Anemia/Blood Disease	___/___ Diabetes	___/___ Kidney/Bladder Problems	___/___ STD's
___/___ Asthma	___/___ Dizziness/Fainting	___/___ Menstrual Problems	___/___ Swollen Glands
___/___ Back Pain	___/___ Frequent Headaches	___/___ Migraine Headaches	___/___ Urinary Infections
___/___ Broken Bones	___/___ Frequent Sore Throats	___/___ Mononucleosis	___/___ Vaginal Infections
___/___ Chicken Pox	___/___ Frequent Stomachaches	___/___ Pelvic Disease	___/___ Weight Problems
___/___ Ear Problems-Hearing	___/___ Heart Murmur	___/___ Pregnancy	Other: _____

Family History:

Has anyone in your FAMILY had any of the following? If yes please √ and give their relationship to student.

YES	Relationship	YES	Relationship	YES	Relationship
___ Arthritis	_____	___ Heart Disease	_____	___ Respiratory Disease	_____
___ Asthma	_____	___ High Blood Pressure	_____	___ Seizure Disorder	_____
___ Blood Disorder	_____	___ Kidney Disease	_____	___ Stroke	_____
___ Cancer	_____	___ Mental Illness	_____	___ Substance Abuse	_____
___ Diabetes	_____	___ Migraines	_____	___ Tuberculosis	_____
___ Female Problems	_____	___ Thyroid Disease	_____	___ Other	_____

I have read the brochure "Your School Based Health Center" which lists services provided by Integrated Health Services *SBHC program to children within the East Hartford Area Schools. I give my child permission to receive any services offered by IHS at the SBHC, and am aware that this form will serve as permission throughout their transition from elementary to high school unless I submit a written request to terminate this agreement. I understand that student visits to the SBHC are confidential and information will be released by SBHC only in compliance with the law. I authorize IHS to exchange Health and Education records with my child's school district for the purpose of providing care and treatment. I give the SBHC permission to release information regarding treatment and/or services, including those related to Mental Health, HIV, and AIDS to my insurance providers for the sole purpose of billing. I hereby assign all my rights for payment to IHS, and authorize that insurance payments be made directly to Integrated Health Services, Inc. for services provided to my child at the SBHC.

_____ _____

Parent/Guardian Name (Please Print) Phone Number

_____ _____

Parent/Guardian Signature Date

INTEGRATED HEALTH SERVICES, INC.

SCHOOL/GRADE:_____
DATE:_____

SERVICIOS INTEGRADOS DE SALUD , INC
PROGRAMA DEL CENTRO DE SALUD

FORMA DE CONSENTIMIENTO
Ofrecemos: Cuidado médico, dental y servicios de consejería

Esta forma es en referencia al tratamiento que su niño/a puede recibir en el centro salud (SBHC) operado por servicios integrados de salud, INC (IHS). Si su niño/a es menor de 18 años, por favor llene , firme, y ponga fecha en esta forma de consentimiento para que el/ella pueda recibir los servicios otorgados por el servicio integrado de salud (IHS) y entreguela junto con la forma de HIPAA al centro de salud (SBHC).

Nombre del Estudiante: _____ Sexo: F__ M__
Apellido Inicial Nombre

Dirección:_____ Ciudad:_____ Código postal:_____

Fecha de Nacimiento:_____ No de Teléfono:_____ Seguro Social:_____

Informacion del Contacto

Nombre:_____ No de Teléfono de Casa_____No de Trabajo_____
Relacion al Estudiante: Padre____ Guardian____ Other_____

Raza del Estudiante:(Información solo pedida por el programa de SBHC para el uso estadístico y demográfico)

_____ Asiático _____ Indio Norteamericano/Nativo de Alaska _____ Moreno/Afro-Americano/Haitiano
_____ Caucásico _____ Nativo Hawaiano/Otro Isleño Pacífico _____ Otro

Etnicidad del Estudiante:(Información solo pedida por el programa de SBHC para el uso estadístico y demográfico)

_____ Hispano/Latino _____ No Hispano/No Latino

Informacióndel Seguro del Estudiante del SBHC

La información del seguro sobre cada estudiante es Mandatorio por el Estado;por consiguiente, por favor complete todo en esta sección

El niño no tiene cobertura de seguro _____ Por favor de la razón _____
***Información de Medicaid/Husky**: Numero del Medicaid del Niño: _____
***Información del Seguro Privado/Primario**: Nombre del seguro: _____
Dirección para enviar los reclamos (escrito atrás de la tarjeta de seguro)_____
de la póliza: _____# Grupo: _____Nombre del Empleador:_____
Fecha de nacimiento del asegurado: _____ Parentesco con el Niño:_____

El niño Recibe Cuidado Médico:

_____Centro de Salud en la Escuela _____ Hospital/Clínica _____ Centro de salud comunitario

_____Sala de Emergencia _____Clínica Militar _____ Clínica de Cuidado Urgente
_____Médico Privado _____Ninguno _____Otro

Médico/Clínica del Niño: _____ Dentista/Clínica:_____

Historia Médica del Estudiante: (Por favor anote la fecha y el problema)
Edad de la Primera Menstruación: _____
Medicación para las Alergias: _____
Medicación: Por favor anote todas las medicinas que toma el niño/a presentemente-Prescripción/Comprada:
_____
Otras Alergias: (Comida, Polen, Animales) _____
Accidentes: _____Sobredosis/Envenenamiento: _____
Hospitalización: _____Cirugías:_____
Heridas:_____Otra Enfermedad, Específique:_____

Por favor marque una X cualquier problema que el estudiante ha tenido:

_____ Adicción a Drogas/Alcohol	_____ Mareos/Desmayos	_____ Enfermedad Pélvica
_____Alergias	_____Frequente Dolor de Cabeza	_____Embarazo
_____Enfermedad de la sangre/Anemia	_____Frequente Dolor de Garganta	_____Fiebre Reumática
_____Asma	_____Frequente Dolor de Estómago	_____Problemas de la Piel
_____Dolor de Espalda	_____Murmullo del Corazón	_____ STD
_____Huesos Fracturados	_____ Presión Alta de Sangre	_____Glándulas Hinchadas
_____Varicela	_____ Dolor de Coyunturas	_____Infección Urinaria
_____Problemas de Oído/Audición	_____Problemas de Riñón/Vejiga	_____Infección Vaginal
_____Problemas Emocionales	_____Problemas con la Menstruación	_____Problemas de Peso
_____Problemas de la vista/ Lentes	_____Dolores de Cabeza/Migrañas	_____Diabetes
_____Mononucleosis	_____ Otro	

Historia familiar: Ha tenido alguien en su familia alguna enfermedad de las siguientes y Quién?

_____Artritis	_____Enfermedad del Corazón	_____Enfermedad Respiratoria
_____Asma	_____Presión Alta de Sangre	_____Ataque de Epilepsia
_____Desorden de la Sangre	_____Enfermedad de los Riñones	_____Apoplejía
_____Cáncer	_____Enfermedad Mental	_____Abuso de Sustancias
_____Diabetes	_____Migrañas	_____Tuberculosis
_____Problemas de la Mujer	_____Tiroides	_____Otro

Yo he leído el folleto "Su Centro de Salud Basado en la Escuela" que lista servicios brindados por el Programa de los Servicios Integrados de Salud,INC.,SBHC, a niños dentro de las Escuelas Públicas de East Hartford. Yo doy permiso para que mi niño reciba cualquier servicio ofrecido por el SBHC, y entiendo que esta forma servirá como permiso en todas partes de su transición desde la escuela elemental hasta la escuela superior a menos que Yo someta por escrito una petición para terminar este acuerdo. Las visitas del estudiante al SBHC es confidencial y toda información se divulgara a discreción de la enfermera del SBHC y trabajadora social. Yo le doy permiso al SBHC para divulgar información con respecto al tratamiento y/o servicios incluyendo los relacionados al Abuso de Sustancias,Salud Mental, HIV, y SIDA a los proveedores de los seguros listados para el propósito de facturación. Yo autorizo que los pagos del seguro sean efectuados directamente a los Servicios de Salud Integrados, INC, por los servicios proporcionado.

_____ _____
Nombre del Padre/Guardian (letra imprenta) Número de Teléfono

_____ _____
Firma del Padre/Guardian Fecha

INTEGRATED HEALTH SERVICES, INC.

School Based Health Center Galvin Dental Program
East Hartford, CT 06108
860-622-5732

Dear Parent or Guardian,

In order to maintain good oral health it is important that your child be seen for dental care on a regular basis. One benefit of the schools dental program is the services are provided while your child is in school! This eliminates the need for you to take time off from work and to take them out of school to receive dental care.

The School Based Health Center Dental Program offers the following dental services:

- Prophylaxis (cleaning)
- Dental Exam
- Fluoride treatment
- Sealants
- Screening
- X-rays

If you would like your child to receive the above dental services by our dental team, please sign and return this form to the staff at the School Based Health Center as soon as possible. *Restoration/fillings* will only be completed with additional approval.

If you have an outside dental provider - we thank you and will update our records.

Sincerely,

The Dental Team

Please check the appropriate box, sign and return.

STUDENT NAME: _____

( ) Yes, I would like my child to receive the above dental services

Signature of Parent/Guardian _____Date_____

( ) No, I do not want the SBHC to treat my child. I will bring my child to another dentist.

Dentist/Clinic Name_____

Signature of Parent/Guardian_____ Date _____

Best phone number to contact you at _____

INTEGRATED HEALTH SERVICES, INC.

School Based Health Center Galvin Denta
East Hartford, CT 06108
860-622-5732

Estimado Padre o Tutor,

A fin de mantener una buena salud bucal es importante que su hijo sea visto para el cuidado dental sobre una base regular. Uno de los beneficios del programa dental estando en la escuela es que los servicios son proporcionados mientras su hijo está en la escuela! Esto elimina la necesidad de tomar tiempo libre del trabajo y sacarlos de la escuela para recibir cuidado dental.

El programa Dental del Centro de Salud Escolar ofrece los siguientes servicios:

- Profilaxis dental (limpieza)
- Examen Dental
- Tratamiento de fluoruro
- Sellantes
- Exámenes Visual
- RAYOS-X

Si usted quisiera que su hijo reciba los servicios dentales por nuestro equipo dental, por favor, firme y devuelve este formulario al personal del Centro de Salud Escolar tan pronto como sea posible. Restauración/empastes sólo se terminará con aprobación adicional.

Si tienes un proveedor dental exterior - le damos las gracias y actualizaremos nuestros registros.

Atentamente,

El equipo dental

Por favor marque la casilla apropiada, firmar y devuelve.

Nombre del estudiante: _____

( ) Sí, me gustaría que mi hijo reciba los mencionados servicios dentales

Firma del Padre/Madre/Tutor _____Fecha_____

( ) No, no quiero que la SBHC para tratar a mi hijo. Voy a llevar a mi niño a otro dentista.

Dentista/Clínica Nombre_____

Firma del Padre/Madre/Tutor _____Fecha _____

Mejor número de teléfono para contactar con usted en _____

INTEGRATED HEALTH SERVICES, INC.

Connecticut River Academy
9 Riverside Drive
East Hartford, CT 06118

Dear Parent or Guardian,

This December the Dental Hygienist of the School Based Health Center will conduct a visual dental screening at CTRA. This screening will NOT include x-rays. Information gathered will be held in the highest confidentiality.

This screening will help determine the dental condition and overall oral health needs of our school children, but could also be used to determine if your child could benefit from the services we provide. After the screening, we will send home a letter to let you know the results of the screening and if your child would benefit from our dental services. The dental clinic is located right on premises at CTRA. Services include bi-annual cleanings, fillings, and x-rays (if needed) by licensed dentists and dental hygienists. **There is no cost for this screening.**

If you choose to have your child receive further dental care from our clinic we will be happy to assist you with any insurance questions or concerns. Preventive dental care including cleanings, fillings, x-rays, sealants and fluoride treatments are covered by Husky. We do not submit to private insurance but are able to provide you with a receipt for you to submit to your insurance. If you have no or limited insurance our staff would be happy to assist you in making sure your child receives the dental care he/she needs.

Your child's participation in this program is important. If you DO NOT wish your child to participate, please return this form to the school by December 12th. If you have any questions, please don't hesitate to call the school nurse at 860-310-2865.

Sincerely,

Linda Dadona, Principal

[ ] I DO NOT WANT my child to participate in the dental screening

*If the form is not returned or a box is not checked off, your child WILL be included in the dental screening

_____ _____

Child's Name Grade

_____

Signature of Parent or Guardian

INTEGRATED HEALTH SERVICES, INC.

Galvin Dental Program
School Based Health Center (SBHC)
East Hartford, CT 06108

Dear Parent/Guardian, Date:_____

Child Name: _____

A dental screening was completed on your child and the following is suggested:

- ❑ Continue with routine care
- ❑ A dental exam and restorative care **is needed** soon
- ❑ Your child requires **immediate attention** due to evidence of visible decay

If you would like the SBHC to take care of your child's dental needs please sign and return this form.

If you are not yet registered with the SBHC - please ALSO complete and return the attached paperwork.

If you already have a dental provider – thank you! Please fill in the information below and we will update our records.

BENEFITS TO YOU - The SBHC dental team takes care of your child's dental needs while they are in school so there is no need to take them elsewhere!

Services recommended by the SBHC:

- ❑ Examination by the dentist
- ❑ X-Rays (taken one time per year)
- ❑ Sealants
- ❑ Restorations
- ❑ Dental cleaning, screening and fluoride application every 6 months

Please check the appropriate box, sign, and return this form.

□ **Yes, I would like my child to receive the recommended service by the SBHC.**

Parent Signature_____**Date**_____

□ **No, I do not want the SBHC to treat my child. I will bring my child to another dentist.**

Dentist/Clinic Name_____ Phone number_____

Parent Signature_____**Date**_____

Note: During dental procedures, plans can easily change. If a procedure becomes more involved than was originally planned, we will contact you before proceeding. By signing this form, you are giving the SBHC consent to treat your child for the procedures outlined above.

Thank you from the SBHC Dental Staff
Please call the SBHC if you have any questions: (860) 622-5732

_____Initial
ScreeningTakeHomeForm.docx

Mission Statement

Integrated Health Services, Inc. (IHS) is a non-profit organization whose mission shall include the provision of comprehensive and preventive health care services, including medical, mental health and dental services, to children and their families who are either uninsured, underinsured or without access to a health care provider. Currently IHS provides these services to children and families through their School Based Health Center Program in 5 of East Hartford's Schools. Plans to create programs to expand services outside of the school system are being developed.

Providing medical, dental and counseling services to your children

- Healthy Relationships Groups
- Anger Management Groups
- Nutritional Awareness
- Fitness Group (Wii Fit)
- Asthma Awareness
- Iron Deficiency Screening
- Blood Pressure Screening
- Diabetes Screening
- Sports Physicals
- Immunizations
- STD Screening
- Dental cleanings
- Restorative Dental Care
- Individual Counseling
- Family Counseling
- Peer Counseling

EH SBHC Locations

East Hartford High School
Main Office : 860-622-5340

East Hartford Middle School
Main Office: 860-622-5670

Silver Lane Elementary School
Main Office: 860-622-5514

Hockanum Elementary School
Main Office :860-622-5449

Mayberry Elementary School
Main Office: 860-622-5731

Early Childhood Magnet School
@Goodwin College
Social Workers Office: 860-709-6810
School Nurse: 860-709-6812

Connecticut River Academy (CTRA)
@ Goodwin College
School Nurse: 860-310-2865
Dental 860-310-2862

Goodwin College
Social Workers Office: 860-913-2072

INTEGRATED HEALTH SERVICES, INC.

INTEGRATED HEALTH SERVICES, INC.

Your School Based Health Center

Healthy Kids Bright Futures

Integrated Health Services Inc.
763 Burnside Avenue
East Hartford, CT 06108
www.integratedhealthservices.org

A FAMILY - SCHOOL - COMMUNITY PARTNERSHIP DEDICATED TO HEALTHY CHILDREN & FAMILIES

Some of the services available at your School Based Health Center (SBHC):

PRIMARY PREVENTATIVE HEALTH CARE AND SERVICES *Physical exams, immunizations, selected laboratory tests, prescription and dispensing of medications, nutrition and exercise counseling, weight management, referral and follow up for specialty care.*

ACUTE CARE OF COMMON INJURIES AND ILLNESSES *Allergies, conjunctivitis, colds, ear infections, sore throats, sinus infections, skin problems, gastrointestinal issues, diagnosis and treatment of sexually transmitted illnesses, asthma, sprains and strains, wound care.*

COUNSELING AND SOCIAL WORK *Mental health services, crisis intervention, individual, family and group counseling. Emotional support and referrals, case management and follow-up.*

DENTAL *Preventative Care, Cleanings/fluoride treatments, sealants. Restorative Care, X-rays, composite fillings, and extractions.*

School Based Health Centers

Is a health center located in certain schools in the East Hartford Public School System. School Based Health Centers provide physical, behavioral and dental health care services to children who have Medicaid, are privately insured, uninsured, or to those without ACCESS to primary health care services.

SBHC Fact:

•School Based Health Centers remove the barriers to care such as; transportation, unnecessary time off from work/school for preventative or acute care, or cancelled appointments.

The SBHC Program, under IHS, is based upon our belief that....

"It takes a community to raise a child."

The most cost - effective, time-efficient and comprehensive health care for children is accomplished through the collaborative efforts of community and the School Based Health Center.

Open to ALL

All children enrolled in the East Hartford Public School System may use our services with a signed Parent Permission Form, regardless of income or health care coverage. Services are aimed at, but not limited to, students who do not have access to a family doctor or whose families have little or no health care insurance.

School Based Health Centers work closely and in conjunction with school personnel. Although the SBHC staff work closely with the School Nurse and School Social Worker to care for our students., the SBHC staff ensures the confidentiality of the children and families it serves.

It is the mission of the School Based Health Centers to help students learn about health and well being. Each center emphasizes early identification of physical and mental health concerns, and the prevention of more serious problems by early treatment.

HEALTHY KIDS MAKE BETTER LEARNERS

INTEGRATED HEALTH SERVICES, INC.

School Based Health Center
Galvin Dental Program

AREA DENTISTS AND DENTAL CLINIC REFERRALS

East Windsor:		
Smiles in Bloom	137 Prospect Hill rd. East Windsor, CT 06088	860-254-5840
East Hartford:		
First Choice Health Center	94 Connecticut Blvd.	860-528-1359
Michael Hwang, DMD	1175 Main St.	860-528-3427
iSmile Family Dentistry	765-777 Main St.	860-216-3585
Dr. Kwon	1011 Main St.	860-528-3350
Manchester		
Manchester Community Health Care	150 N. Main St.	860-646-4678
Columbia Dental	401 Center St.	860-645-0111
Hartford:		
UCONN Burgdorf	131 Coventry St.	860-714-2141
Community Health Services	520 Albany Ave.	860-725-6901
Charter Oak Health Ctr.	21 Grand St.	860-550-7500
Small Smiles	272 Franklin Ave.	860-296-5437
Orthodontist (Braces)		
UCONN Dental School	Farmington, CT	860-679-2000
East Hartford Orthodontics	110 Connecticut Blvd.	860-289-9379
Endodontics (root canal)		
Dr.Carrington	436 Farmington Ave. Hartford, CT 06105	860-233-7777
Oral Surgeon		
Dr.Saunders	945 Main St. Suite 310 Manchester, CT 06040	860 647 9926.

DF3 lkb4/2015

East Hartford
ORTHODONTICS, LLC

Jeffrey Dixon, DDS, MS
Benson Monastersky, DMD

REFERRAL FORM

date .....

INTRODUCING OUR PATIENT

name .....

address .....

.....

phone .....

date of birth .....

REFERRING DOCTOR/HYGIENIST

name .....

practice .....

address .....

.....

email .....

PLEASE EVALUATE FOR THE FOLLOWING

- ○ Skeletal Discrepancy
- ○ Crowding
- ○ Spacing
- ○ Posterior Crossbite
- ○ Anterior Crossbite
- ○ Other .....

.....

- ○ Impaction
- ○ Excessive Overbite
- ○ Anterior Open bite
- ○ Ectopic Eruption
- ○ Excessive Overjet

- ○ Habit
- ○ TMJ Evaluation
- ○ Occlsual Interference
- ○ Space Maintenance

appointment date .....

time .....:.....o'clock am / pm

patient records sent by email yes / no

restorative/periodontal tx pending yes / no

477 Connecticut Blvd. Suite 105, East Hartford, CT 06108
860 289 9397 phone 860 528 3129 fax

CARE ENDODONTICS, P.C.
CHRIS W. CARRINGTON, D.D.S., M.S.D.
LESTER C. REID, D.M.D., M.S.D.
REKHA PAWAR, D.D.S., M.D.S.
436 Farmington Ave.
Hartford, Connecticut 06105
(860) 233-7777
Practice Limited to Endodontics

Patients Name: _____

Referred by Doctor: _____

Patient's Right

Patient's Left

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Treatment: _____

Rationale: _____

_____

Directions on the back of this form.

Oral Facial Surgery Center

Paul C. Peracchio, DMD • Daniel R. Saunders, DMD

945 Main Street, Ste 310
Manchester, CT 06040
Tel. (860) 647-9926
Fax (860) 645-7723

520 Hartford Turnpike, Unit H
Vernon, CT 06066
Tel. (860) 872-8575
Fax (860) 872-1362

www.oral-facial.com

Patient Name_____

Medical History_____

SERVICES REQUEST

- ☐ Extraction
- ☐ Impaction
- ☐ Socket Graft
- ☐ Apicoectomy
- ☐ Biopsy
- ☐ Implant
- ☐ Pre-Prosthetic Surg.
- ☐ Surgical Exposure
- ☐ Orthognathic Surg.
- ☐ TMJ Disorder
- ☐ X-rays mailed
- ☐ X-rays given to patient
- ☐ Please take X-ray
- ☐ I-CAT 3D-image

Please indicate teeth ☞

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Right	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	**Left**

	A	B	C	D	E	F	G	H	I	J
	T	S	R	Q	P	O	N	M	L	K

ADDITIONAL COMMENTS:

Referring Doctor:_____ Date:_____

APPOINTMENT DATE:_____ TIME:_____

Note: Patients who wish to go to sleep for extractions must abstain from food and liquid from midnight before surgery. Bring a driver with you into the waiting room. Driver must remain in waiting room and drive you home following surgery.

Sterilization Log

Date(s):_from:_____to:_____

Sterilizer Name_____ Sterilizer Serial #_____ Location Address /Room #_____

Sterilization Monitoring Service _____

Account ID: # _____Account Telephone number: _____Contact _____at___ in the event of a failure.

Date	Load #	Operator name/initials	Time sterilizer loaded	BI/Spore test performed **Y/N**	Load/content (e.g., pouches, cassettes, etc.)	Time	Temp	PSI	Chemical Integrator Test Card Result: Pass/ Fail *(File integrator cycle/load card chronologically by load and date. File in designated file box located_____.)*