

SMILE ON WHEELS

Mobile Dental Hygiene Services



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CONSENT FOR TREATMENT

Patient's Name: _____ **Sex:** _____

Patient's Home Address: _____

City, State, Zip: _____

Social Security #: _____ - _____ - _____ **Birthdate:** _____

Name of Special Care Facility: _____

Facility Address: _____ **City, State, Zip:** _____ **Phone:** _____

Facility Contact Name: _____ **Title:** _____

Name of Physician: _____ **Physician's Address:** _____

City, State, Zip: _____ **Physician's Phone:** _____

Kaiser # (if applicable): _____ **Physician's Fax:** _____

Name of Dentist: _____

Dentist's Phone: _____

Describe current or long-term disability/ medical condition:

Please Circle all that apply:	High Blood Pressure	Yes	No	Radiation Therapy	Yes
		No			
Heart Murmur	Yes	No	Mitral Valve Prolapse	Yes	No
				Cerebral Palsy	Yes
Heart Pacemaker	Yes	No	Hip/Joint Replacement	Yes	No
				Multiple Sclerosis	Yes
Hemophilia	Yes	No	Hepatitis	Yes	No
				Blindness	Yes
H.I.V. Positive	Yes	No	Epilepsy or Seizures	Yes	No
				Deaf	Yes
Diabetes	Yes	No	Stroke	Yes	No
				Parkinson's disease	Yes
Allergies	Yes	No	Dementia	Yes	No
Specify any Allergies:				Alzheimer's disease	Yes
					No

Patient Trust accounts may be billed for Dental Hygiene Treatment.

Permission is authorized for third-party (insurance) payment directly to **Smile on Wheels**. **All fees are ultimately the responsibility of the Responsible Party**. All fees are due 30 days from date of invoice. After 30 days, a \$25 per month Rebill/ Late Fee will be assessed.

Type of Billing: (please check) Private Funds

Date of last cleaning: _____

Permission is granted for application of Interim caries arresting medicament **Silver diamine fluoride (SDF)**-a conservative treatment of an active, non-symptomatic carious lesion by topical application of caries arresting, inhibiting medicament without mechanical removal of sound tooth structure.

CONSENT FOR TREATMENT

(Continued)

Patient Name: _____ **Facility Name:** _____

In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information that describes how we may use and disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that are permitted or required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health/ dental information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your care.

We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

NAME OF RESPONSIBLE PARTY: _____

Phone: _____ **Fax:** _____

Mailing/ Billing Address:

Relationship to Patient: _____

Permission Granted for Review of Medical Records.

Permission Granted to take pictures of patient for chart identification and educational purposes.

Permission Granted to use Silver Diamine Fluoride: Interim caries (decay) arresting medication applications.

All fees are ultimately the responsibility of the "Responsible Party."

SIGNATURE OF RESPONSIBLE PARTY: _____ **Date:** _____

SIGNATURE OF POWER OF ATTORNEY FOR HEALTH CARE: _____ **Date:** _____