

# DENTAL HYGIENE OUT & ABOUT

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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 Address: \_\_\_\_\_ Dentist's Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Dentist's Fax: \_\_\_\_\_

### 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	No
Heart Pacemaker	Yes No	Hip/Joint Replacement	Yes	No	Multiple Sclerosis	Yes	No
Hemophilia	Yes No	Hepatitis	Yes	No	Blindness	Yes	No
H.I.V. Positive	Yes No	Epilepsy or Seizures	Yes	No	Deaf	Yes	No
Diabetes	Yes No	Stroke	Yes	No	Parkinson's Disease	Yes	No
Allergies	Yes No	Dementia	Yes	No	Alzheimer's Disease	Yes	No

Specify any Allergies: \_\_\_\_\_

Medi-Cal, Share-of-Cost Medi-Cal, Patient Trust accounts or Private Dental Insurance may be billed for Dental Hygiene Treatment. Permission is authorized for third-party (insurance) payment directly to Dental Hygiene Out & About. **All fees are ultimately the responsibility of the Responsible Party.** All fees are due in 30 days from date of invoice. After 30 days, a \$10 per month ReBill/ Late Fee will be assessed.

Type of Billing: (please check) \_\_\_\_\_ Private Funds \_\_\_\_\_ Medi-Cal ID No. \_\_\_\_\_  
 \_\_\_\_\_ Dental Insurance – Please see page 2 for insurance information

Please attach copy of current Medi-Cal Benefits Identification Card Medi-Cal Card Issue Date: \_\_\_\_\_

Medi-Cal coverage for dental hygiene is usually once per full 12 month period. Special conditions and/or medications may determine more frequent treatment. Permission is granted to use Medi-Cal Share of Cost funds if available.

Date of last cleaning: \_\_\_\_\_

# CONSENT FOR TREATMENT

(Continued)

**Patient Name:** \_\_\_\_\_ **Facility Name:** \_\_\_\_\_

**Name of Dental Insurance:** \_\_\_\_\_

**Group Name:** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Send Claims to (address):** \_\_\_\_\_

**Name of Primary Insured:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Soc. Sec. # of Primary Insured:** \_\_\_\_\_ **Birth Date of Primary Insured:** \_\_\_\_\_

**Dental Insurance Phone Number (for eligibility and claim information):** \_\_\_\_\_

**All Information regarding dental insurance is necessary. If information is not complete, treatment may be delayed or you may be billed directly.**

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:** \_\_\_\_\_  
Please Print

**Fax:** \_\_\_\_\_

**Mailing/ Billing Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

To whom can we thank for referring you to us: **Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

Permission Granted for Review of Medical Records.

An associate RDHAP may be the provider of mobile dental hygiene services.

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

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

**SIGNATURE OF RESPONSIBLE PARTY:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SIGNATURE OF POWER OF ATTORNEY  
FOR HEALTH CARE:** \_\_\_\_\_ **Date:** \_\_\_\_\_