ICF
MOBILE DENTAL HYGIENE CARE

Denise Cozza, RDHAP, #189
P.O. Box 406
Arroyo Grande, CA 93421
(805) 441-0454
sdcozza@pacbell.net

CONSENT FOR TREATMENT

www.smilecareprovider.com

(download consent form)

Maureen Kaye, RDHAP, #171
P.O. Box 2357
Atascadero, CA. 93423
(805) 268-9874
mk@smilecareprovider.com

Patient Name: _____Sex: Male Female

Patient's Home Address: _____

City, State, Zip _____

Birth Date: _____ Primary Diagnosis_____

Phone: _____

Name of Dentist: (if applicable) _____

Dentist's Phone: _____

Date of last dental visit: year? _____

Name of Physician: _____Phone number: **( )** _____

Current or long-term disability/medical condition: (Please circle "Yes" or "No")

Heart Murmur	Yes	No	High Blood Pressure	Yes	No	Radiation Therapy	Yes	No
Heart Pacemaker	Yes	No	Mitral Valve Prolapse	Yes	No	Cerebral Palsy	Yes	No
Hemophilia	Yes	No	Hip/Joint Replacement	Yes	No	Multiple Sclerosis	Yes	No
H.I.V. Positive	Yes	No	Hepatitis	Yes	No	Blindness	Yes	No
Drug Addiction	Yes	No	Epilepsy or Seizures Stroke	Yes	No	Deaf	Yes	No
Head Trauma	Yes	No	Down's Syndrome	Yes	No	Dementia	Yes	No
Schizophrenia	Yes	No	Diabetes	Yes	No	Other_____		

Specify any Allergies: _____

Taking any medications? _____

Social Security Number: _____

Services provided: scaling & polishing of teeth, Fluoride treatment, oral cancer screening, assess oral condition/needs

Medi-Cal ID # (BIC) _____Other insurance _____

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 dental health 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.

Sign Consent to Treat: _____

(Parent, Guardian, Conservator or if participant is a minor)