

MOBILE DENTAL HYGIENE CARE

Consent For Treatment

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(download consent form)
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Patient Name: _____ Male Female

Home Address: _____

City, State, Zip Code: _____

Birth Date: _____ UCI # _____

Phone: _____

Name of Dentist: _____ Phone Number: _____

Date of last dental visit: Year? _____

Name of Physician: _____ Phone Number: _____

Current or long-term disability/medical condition: PLEASE CIRCLE "YES" OR "NO" after each:

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	Yes	No	Deaf	Yes	No
Head Trauma	Yes	No	Stroke	Yes	No	Dementia	Yes	No
Schizophrenia	Yes	No	Diabetes	Yes	No	Other	_____	

Specify any Allergies: _____

Taking any medications? (can attach list) _____

*Services provided: Assess oral condition/needs, oral cancer screening, scaling & polishing of teeth, Fluoride application, review daily oral hygiene care, oral hygiene instructions. Advise Regional Center of any dental needs/emergencies.

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 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 diagnosis 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.

Patient Signature: _____ Date: _____

Parent, Guardian, Conservator: _____