

CONSENT FOR TREATMENT

Patient Name: _____ Sex: ___ Birthdate: _____

Home Address: _____

City: _____ State/Zip: _____ Social Security: _____ - _____ - _____

Name of Special Care Facility: _____

Facility Address: _____ Phone: _____

Facility Contact Name: _____ Title: _____

Name of Physician: _____ Phone: _____ Fax: _____

Physician's Address: _____ City: _____ Zip: _____

Name of Dentist: _____ Phone: _____ Fax: _____

Dentist's Address: _____ City: _____ Zip: _____

Describe current or long- term disability/medical condition:

Are you taking any medication? If yes, please list name and dosage and why:

Name: _____ Dose: _____ For: _____

Name: _____ Dose: _____ For: _____

Name: _____ Dose: _____ For: _____

Name: _____ Dose: _____ For: _____

(If more space needed, please write on the back of this sheet.)

Please mark all that apply:

- | | | | | | |
|------------------------------|-----|-----------------------------|-----|------------------------|-----|
| Heart Murmur | ___ | Hypertrophic Cardiomyopathy | ___ | High Blood Pressure | ___ |
| Heart Pacemaker | ___ | Mitral Valve Prolapse | ___ | Artificial Heart Valve | ___ |
| Organ Transplant | ___ | Hip/Knee/Joint Replacement | ___ | Hemophilia | ___ |
| Diabetes (Type I/II) | ___ | Radiation Therapy | ___ | Cerebral Palsy | ___ |
| HIV/AIDS | ___ | Hepatitis (A/ B/ C) | ___ | Stroke | ___ |
| Multiple Sclerosis | ___ | Epilepsy or Seizure | ___ | Blindness/Deaf | ___ |
| Allergies | ___ | Allergic to: _____ | | Dry Mouth | ___ |
| Dementia/Alzheimer's Disease | ___ | Parkinson Disease | ___ | Mental Disorder | ___ |

Other: _____

Date of last dental cleaning _____ Any Dental Concerns _____ **(OVER)**

Patient's Name _____

Dental Insurance Company: _____ Phone #: _____

Group Name: _____ Group #: _____

Insurance Claim Address: _____

Name of Insured: _____ Relationship to Patient: _____

Social Security # of Insured: _____ Birth Date of Insured: _____

In accordance with the Privacy Regulation created by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 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 service. 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.

(Please Print)

Name of Responsible Party: _____ Phone: _____

Relationship to Patient: _____ Fax: _____

Mailing/Billing Address: _____

City/ State/Zip: _____

To whom can we thank for referring you? _____

Permission granted for review of medical record.

Permission granted to take pictures of patient for chart identification and education purposes.

All fees are ultimately the responsibility of the person signing this form.

Signature of Responsible Party: _____ Date: _____

Power of Attorney for Health Care Signature: _____ Date: _____