

## Gentle Touch Home Dental Hygiene Service

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Phone (619) 957-6561 Fax (619) 512-4689

### Consent for Treatment

Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of the Special Care Facility: \_\_\_\_\_

Facility Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Facility Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Name of Physician : \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Describe current or long-term disability/medical condition:

\_\_\_\_\_

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

\_\_\_\_\_

**Please mark all that apply:**

Heart Murmur \_\_\_\_\_ Hypertrophic Cardiomyopathy \_\_\_\_\_ High Blood Pressure \_\_\_\_\_

Heart Pacemaker \_\_\_\_\_ Mitral Valve Prolase \_\_\_\_\_ 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 \_\_\_\_\_

Dementia/Alzheimer's Disease \_\_\_\_\_ Parkinson Disease \_\_\_\_\_ Allergies \_\_\_\_\_

Mental Disorder \_\_\_\_\_ Allergic to \_\_\_\_\_

Other: \_\_\_\_\_

Medi-Cal, Share-Of-Cost Medi-Cal, Patient Trust accounts or Private Insurance may be billed for the Dental Hygiene Treatment. Permission is authorized for third-party (insurance) payment directly to Gentle Touch Home Dental Hygiene Service. All fees are fully the responsibility of the Responsible Party. All fees are due 21 days from date of invoice. A \$15.00 late fee will be charged after 21 days.

Type of Billing: \_\_\_ Private Fund \_\_\_ Dental Insurance (please see page 2 for insurance information)

\_\_\_ Medi-Cal ID # \_\_\_\_\_ Date of Issue \_\_\_\_\_

(For Medi-Cal, please attach copy of current Medi-Cal Benefits Identification Card)

Medi-Cal coverage for dental hygiene is once per year. However, special conditions and/or medications may require treatment that is more frequent. Permission is granted to use Med-Cal Share Cost funds if available.

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

# Consent for Treatment

(continued)

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

Name of Responsible Party: \_\_\_\_\_ Phone: \_\_\_\_\_

(Please Print)

Relationship to Patient: \_\_\_\_\_ Fax: \_\_\_\_\_

Mailing/Billing

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

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

**Permission granted for review of medical record.**

**An associate RDHAP may be the provider of Gentle Touch Home Dental Hygiene Service.**

**Permission for allowing pictures taking on patient for chart identification and education purposes.**

All fees are fully the responsibility of the "Responsible Party"

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Power of Attorney for Health Care Signature: \_\_\_\_\_ Date: \_\_\_\_\_