SoCal Dental Hygiene Group

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CONSENT FOR TREATMENT

Patient Information

Name: _____ Sex: _____

Home Address: _____ City, State, Zip: _____

Social Security: _____ _____ _____ Date of Birth: _____

Special Care Facility Information

Name: _____ Phone: _____

Facility Address: _____ City, State, Zip: _____

Facility Contact Name: _____ Title: _____

Physician Information

Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

ID Number (if applicable): _____ Fax: _____

Dentist Information

Dentist: _____ Phone: _____ Fax: _____

Address: _____ City, State, Zip: _____

Describe current or long-term disability/medical condition:

Please circle all that apply:

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
Diabetes	Yes	No	Epilepsy or Seizures Stroke	Yes	No	Deaf	Yes	No
Allergies	Yes	No	Dementia	Yes	No	Parkinson's Disease	Yes	No
						Alzheimer's Disease	Yes	No

Specify any allergies: _____

List any medications: _____

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 SoCal Dental Hygiene Group. All fees are ultimately the responsibility of the Responsible Party. All fees are due 30 days from date of invoice. After 30 days, a $10 per month Bill/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 a 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: _____

SoCal Dental Hygiene Group

CONSENT FOR TREATMENT
(continued)

Patient Name: _____ **Facility Name:** _____

Name of Dental Insurance: _____

Group Name: _____ Group Number: _____

Send Claims to (address): _____

_____

Name of Insured: _____ Relationship to Patient: _____

SSN of Insured: _____ DOB of 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 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.

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 to approval or to determine whether your plan will cover treatment.

Name of Responsible Party: _____ Phone: _____

Mailing/Billing Address: _____ Fax: _____

City, State, Zip: _____ Relationship to Patient: _____

To whom can we thank for referring you to use: 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".

_____ Date: _____
Signature of Responsible Party

_____ Date: _____
Signature of Power Attorney for Health Care