SHE SMILES
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CONSENT FOR TREATMENT

Patient Name:_____Gender:_____

Patient Home Address:_____

City, State, Zip:_____

Date of Birth_____ Age:_____

Name of Special Care Facility:_____

Facility Address_____City, State, Zip_____

Facility Phone Number:_____

Facility Contact Name:_____

Name of Physician:_____

Physician Address:_____City, State, ZiP_____

Physician Phone Number:_____Physician Fax:_____

Name of Dentist:_____

Dentist Address:_____Dentist Phone:_____

City, State, Zip_____Dentist Fax:_____

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Describe current or long-term disability/ medical condition:

Please circle all that apply

Heart Murmur	YES NO	High Blood Pressure	YES NO	Cerebral Palsy	YES NO
Heart Pacemaker	YES NO	Mitral Valve Prolapse	YES NO	Multiple Sclerosis	YES NO
Hemophilia	YES NO	Hip/Joint replacement	YES NO	Blindness	YES NO
H.I.V. Positive	YES NO	Hepatitis	YES NO	Deaf	YES NO
Diabetes	YES NO	Epilepsy or Seizures	YES NO	Parkinson's Disease	YES NO
Allergies	YES NO	Stroke	YES NO	Alzheimer's Disease	YES NO
Dementia	YES NO	Radiation Therapy	YES NO	Oral Cancer	YES NO

List all Prescription and over the counter medication:

_____

_____

Private Dental Insurance (Delta Dental Only) and Patient Trust accounts may be billed for Dental Hygiene Treatment. Permission is authorized for third-party (insurance) payments directly to SHE SMILES. **All fees are ultimately the responsibility of the responsible party.** All fees are due in 30 days from the date of invoice. After 30 days, a $10.00 per month Rebill/Late Fee will be assessed.

Type of Billing: (please check) ☐ Private Funds

☐ Dental Insurance (Please complete the section below)

Name of Dental Insurance:_____

Group Name:_____Group #_____

Dental Insurance Phone Number (for eligibility and claim Information):_____

Send Claims to (address): _____

_____

Name of Insured:_____Relationship to Patient_____

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

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As a courtesy to you, I will be submitting your insurance forms for you. Estimates of insurance benefits are not a guarantee. Patients and family will be responsible for any fees that are not covered.

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 us 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 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:_____E-Mail_____

Mailing/Billing Address:_____

City, State, Zip:_____Relationship to Patient_____

Permission Granted for Review of Medical Records.
Permission Granted to take pictures of patient for chart identification and educational purpose.
All fees are ultimately the responsibility of the "Responsible Party"

SIGNATURE OF RESPONSIBLE PARTY:_____DATE:_____

SIGNATURE OF POWER OR ATTORNEY
FOR HEALTH CARE:_____DATE:_____