Consent for Treatment

Notification of Privacy Practices

This notice describes how health information about you may be used and disclosed. Please review it carefully.

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. This describes how we may use and disclose your protected health information to carry out treatment, payment of health care and for other purposes that we 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. 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, responsible party or third party.

Responsible Party:

☐Self ☐ Family Member Power of Attorney ☐ Guardian/Facility Holding Power of Attorney

Name:_________________________Relationship to Patient:____________________________________

Phone #:_________________________ Email: ____

Billing Address:____

City:____State:__________Zip Code:__________

Dental Insurance Information:

☐Medicaid ☐ Private Dental Insurance ☐ Self Pay (No Dental Insurance Coverage)

Subscriber:_________________________Social Security #/Member ID #:__________________________

Group #:_______________Date of Birth:___________Patient Relationship to Insured: _______________

Employer:_______________________________Insurance Company: ______________________________

Insurance Address:___________________________________Insurance Co. Phone #: ________________

Patient Information: (if applicable include copy of Facility Face Sheet)

Name:___________________________Date of Birth:______________Care Facility: __________________

Residing Home Address/Facility: _______________________________ City:_________________________

Zip Code: ___________________________Facility Phone #:________________Fax #:_________________

Contact Person:_________________________________Contact Phone #:____________________________

Signature of Patient/POA/Legal Guardian:____________________________________ Date:____________

Medical Dental History
(Important: Please fill out completely)

Patient Name:____ Date of Birth: ___________________

Please list all Medications taken: Medication Administration Record -**MAR** (if applicable, please include copy)

____

____

Preferred Pharmacy:____________________________________ Phone #: _______________________

Medical Dental History

1. Is the patient required to take an antibiotic and/or PRN (Anti-Anxiety) prior to treatment? ☐ No ☐ Yes
   Medication:_______________________________________Reason Needed: ____________________________
2. Reason for today's visit?____
3. Date of last dental care visit: ____
4. Please check ☑ if you experience problems or have any of the following:

   ☐ Bad Breath or Taste ☐ Your Partials or Dentures ☐ Sensitivity to Hot
   ☐ Dry Mouth ☐ Sensitivity to Sweets ☐ Sensitivity to Cold
   ☐ Food Collection in Teeth ☐ Mouth Soreness/Growths ☐ Other: _______________

5. I wear full dentures: ☐ Upper ☐ Lower ☐ Not Applicable

6. Please check ☑ if you have any of the following:

   ☐ Alzheimer's ☐ Deaf ☐ High Blood Pressure ☐ Shortness of Breath
   ☐ Anemia ☐ Dementia ☐ HIV/AIDS ☐ Skin Rash
   ☐ Arthritis, Rheumatism ☐ Diabetes ☐ Jaw Pain ☐ Stomach Ulcer
   ☐ Artificial Heart Valve ☐ Disabled ☐ Kidney Disease ☐ Stroke
   ☐ Artificial Joints ☐ Epilepsy/Seizures ☐ Liver Disease ☐ Thyroid Problems
   ☐ Asthma ☐ Fainting ☐ Multiple Sclerosis ☐ Tobacco Habit
   ☐ Blind ☐ Glaucoma ☐ Pacemaker ☐ Tuberculosis
   ☐ Cancer ☐ Headaches ☐ Parkinson's ☐ Venereal Disease
   ☐ Cerebral Palsy ☐ Heart Problems ☐ Persistent Cough ☐ Other: ___________
   ☐ Chemical Dependency ☐ Hemophilia ☐ Radiation Treatment ☐ Other: ___________
   ☐ Chemotherapy ☐ Hepatitis ☐ Respiratory Disease ☐ Other: ___________

7. Please check ☑ if you have **ALLERGIES** to any of the following:

   ☐ Aspirin ☐ Latex ☐ Local Anesthetic ☐ Other: ___________
   ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Other:___________

The above information is accurate and complete to the best of my knowledge. I will not hold Dental Care in Your Home or any member of the staff responsible for any errors or omissions in the completion of this form.

Signature of Patient/POA/Legal Guardian:____ Date:__________

Please return this form to: Info@DCIYH.org
Dentalcareinyourhome.org | (505) 615-0951 | 1776 Montano Rd. NW Albuquerque, NM 87107

Consent for Silver Diamine Fluoride Therapy
to Arrest Tooth Decay

The use of silver diamine fluoride in dentistry has been well documented for its safe and successful ability to control tooth decay. Its application is a conservative approach for the treatment of active decay. We use SDF on cavities to help stop tooth decay from progressing, we also use it to treat sensitivity. SDF application every 6-12 months may be necessary.

Treatment with SDF does not eliminate the need for dental fillings or crowns to repair function or esthetics. It kills the bacteria responsible for decay and prevents decay from spreading.

After SDF Treatment
(Compendium of Continuing Education in Dentistry, Feb 2016)

Contraindications:
Silver Diamine Fluoride Allergy (very rare)

Procedure:
1. Dry Area
2. Place small amount of SDF on affected area
3. Allow to dry for 1 (one) minute
4. Rinse

Risks related to SDF include but are not limited to:
- The affected area will stain black, permanently. Healthy tooth structure will not stain. Stained tooth structure can be replaced with a filling or a crown.
- Tooth colored fillings or crowns may discolor if SDF is applied to them. Color changes on the surface can normally be polished off. The edge between a tooth and filling may remain stained.
- If accidentally applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off and will disappear in 1-3 weeks.
- There could be a metallic taste, this will go away rapidly.

Alternatives to SDF include but are not limited to:
- No treatment. No treatment will allow untreated decay to continue further damaging tooth structure, possibly leading to pain, infection, or tooth loss.
- Other treatment options include filling or crown, extraction, or referral for advanced care.

I certify that I have read and fully understand the information given to me about SDF. I understand that I may refuse treatment. Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay and no guarantee of success is granted or implied. If the decay is not arrested, further treatment may be necessary. I also understand that this treatment may not be covered by my insurance (if applicable). It is my responsibility to contact my dental insurance company to discuss and understand my policy. I give my consent to have any member of Dental Care in Your Home team, administer Silver Diamine Fluoride on.

☐ *I Permit usage of Silver Diamine fluoride.* ☐ *I DO NOT permit usage of Silver Diamine Fluoride.*

Authorized Date:__________________

Patient Name:_______________________________________Date of Birth: ___________________________

Signature of Patient/POA/Legal Guardian:_________________________________Date: _______________

Relationship to Patient: ____

Consent and Authorization for Dental and/or Medical Services

We appreciate the opportunity to serve you. It is our intent to provide you the finest care possible while ensuring that you fully understand our procedures and treatment. To ensure that your care comes first, we require your consent for Dental Care in Your Home, to treat you under all circumstances while in this facility/ residence as follows:

The undersigned, on behalf of himself/herself, or minor (if applicable) hereby authorizes and consents to any x-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or transport to hospital care (if deemed necessary) to be rendered by Dental Care in Your Home, licensed dental provider in the State of New Mexico.

We make a good faith effort to arrange visits around the needs of our patients and caregivers; due to our mobile dental model, situational and environmental conditions, outside of our control, can delay visits, slow our arrival times, and in rare cases cause us to reschedule our appointments. We encourage care givers to be present for appointments, but with scheduling variables, the assigned time may be subject to change. Please contact our office on you scheduled day if a more accurate arrival time is needed.

(Please check box)

☐ POA/Legal Guardian **plans** to attend dental appointments.

☐ POA/Legal Guardian **does not** plan to attend dental appointments.

I hereby confirm, consent, and agree to the foregoing.

Patient Name:____Date of Birth: ______________________

Signature of Patient/POA/Legal Guardian:________________________________Date:_______________

Relationship to Patient: ____

Please return this form to: Info@DCIYH.org

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Payment and Dental Insurance

Insurance policies vary in the amount that will be paid towards charges.

The proper relationship between the patient, doctor and insurance carrier is often misunderstood. We are in agreement with the principle of dental insurance and equally willing to submit the necessary forms to help you receive the full benefits of your coverage; however, the responsibility of the total treatment fee rests with you, regardless of what we may calculate as your dental benefit. We will do everything possible to determine an accurate estimate of your coverage, but because the insurance policy is an agreement between your employer and the insurance company, that insurance company will only give us an **estimate** of what they will pay either in writing or verbally. We render to you our very best care and please remember there will be a fee for service.

I UNDERSTAND that Dental Care in Your Home, will aid in submitting claims to my insurance company on my behalf. I also understand that I have the final responsibility for payment of all fees for services rendered on my behalf. Unless otherwise noted, I authorize payment of dental benefits to Dental Care in Your Home.

I have fully read, understand, and consent to all the above terms.

Patient Name:____Date of Birth:_______________________

Signature of Patient/POA/Legal Guardian:_________________________________Date:_______________

Relationship to Patient:____

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Medical Clearance Request for
Routine Dental Care

Physician Information:

Name:_______________________________________Phone #: ______________________________________

Address:____Fax #: ___________________

City:____ State: ________ Zip Code: _________________

Patient Information:

Name:____________________________Date of Birth:______________Care Facility: ___________________

Residing Home Address/Facility: ____

City:____ State: ________ Zip Code: _________________

Contact Person:_________________________________Contact Phone #: ____________________________

Please answer the following questions:

1. Does this patient have any medical concerns that would require premedication therapy prior to a routine dental cleaning?

   ☐ No

   ☐ Yes

   Please list any medical concerns: ____
   ____

   Medication(s): ____
   Please call in prescriptions to the patient's pharmacy so they can continue with dental care

2. If the patient is on an anticoagulant, should this medication be stopped prior to treatment?

   ☐ N/A

   ☐ No

   ☐ Yes_______days prior to treatment

3. Is there any other reason for any medications to be added/discontinued or altered prior to non-invasive preventative dental care?

   ☐ No

   ☐ Yes

   Please list any additional reasons: ____
   ____

The above listed patient may have oral hygiene services, including oral screening, oral prophylaxis, periodontal screening, non-surgical periodontal procedures, Chlorhexidine, irrigation and fluoride treatments by any employee of Dental Care in Your Home, PRN at the patient's residence due to the patient's disability or inability to travel and be treated in a traditional dental office. Treatment may be made in conjunction with an annual visit to their dentist.

Physician's Signature:____**Date:**______________________

License #:____

Please return this form to: Info@DCIYH.org

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