GOLDEN SCALERS

Darci Trill, RDHAP #56
Registered Dental Hygienist In Alternative Practice
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CONSENT FOR TREATMENT

Patient name _____ sex _____

Patient home address_____

City, State, Zip _____

Social Security #_____ _____ _____ Birth date _____

Name of Special Care Facility _____

Facility Address _____

Facility Contact Name _____ Title: _____

Name of Physician _____ address _____

City, State, Zip _____Physician phone:_____

Kaiser # (if applicable) _____ physician fax:_____

Name of Dentist _____dentist phone: _____

Dentist address_____ dentist fax:_____

City, State, Zip _____

Describe current of 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/Seizures	yes no	Deafness	yes no
Allergies	yes no	Stroke	yes no	Parkinson's	yes no
		Dementia	yes no	Alzheimer's	yes no

Specify allergies

ALL FEES ARE ULTIMATELY THE RESPONSIBILITY OF THE RESPONSIBLE PARTY.
Patient Trust Accounts or Private Dental Insurance may be billed for dental hygiene treatment. Permission is authorized for third party (insurance) payment directly to **GOLDEN SCALERS.** All fees are due in 30 days from date of invoice. After 30 days, a $10.00 re-bill/late fee will be assessed.

Type of billing (please check) _____ private funds _____ medi-cal ID # _____dental insurance

PLEASE ATTACH COPY OF CURRENT MEDI-CAL BENEFITS ID CARD **MEDI-CAL ISSUE DATE**

Date of last cleaning_____

NAME OF DENTAL INSURANCE_____

GROUP NAME _____ GROUP # _____

Send Claims to (address) _____

_____

Name of insured _____relationship to patient_____

Social Security # of Insured _____ _____ _____ birth date of insured _____

DENTAL INSURANCE PHONE NUMBER _____

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

NAME OF RESPONSIBLE PARTY _____phone_____

Mailing/billing
address_____

City, State, Zip
_____

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

Signature of Responsible Party:_____Date _____

Signature of Power of Attorney_____Date_____
For Health Care