Smiles to Go Dental Consent Form

*1620 E. Main Street, Liberty, MS 39645 *Office: 601.657.1164 *Fax:601.657.5936 *Email:Ashley@smiles2go.net

Long Term Care Facility:_____ **Phone #:** _____

Our **Smiles To Go** team is very honored to come into your facility and provide dental care to the residents. We provide a wide range of dental services to include preventive services (exams, cleanings, xrays) and restorative services (extractions, dentures, fillings, etc.). Our desire is to provide the dental treatment needed to ensure that your dental needs are met. With all of the struggles of limited access to care, we are trying to eliminate some of these hardships by bringing the dental services directly to your facility. All of our equipment is portable and therefore allows us easy access to deliver these services right to your door. Our dentists, hygienists, and dental assistants are so passionate about helping people meet their dental goals in every stage of life. If you are interested in you or a resident receiving these dental services at the long term care facility, then please complete this form and return it to administration or directly to our STG office. If you have any questions, please call our office at 601-657-1164 and we will be glad to assist you. Healthy people lead to healthy communities. Thanks for partnering with our team.

RESIDENT INFORMATION

Full Name: _____ Resident Phone #:_____
Male__ Female__ Birthdate: _____
Address:_____
City: _____ State: _____ Zip: _____
Email: _____
Attending Physician's Name:_____ Phone #:_____
Legal Responsible Party's Full Name: _____ Phone #:_____

RESIDENT INSURANCE: Everyone can receive these services

Social Security Number**:** _____
MEDICAID enrolled: _____YES _____NO - MEDICAID Number: _____
MEDICARE enrolled: _____YES _____NO - MEDICARE Number: _____
Other Insurance: __Yes __No - If yes, name of Insurance: _____
Policy Number:_____ Name of Subscriber: _____
Employer: _____ Subscriber's Date of Birth: _____ Subscriber's SSN: _____

HEALTH HISTORY: Have your ever had any serious health problems listed below: (Please check) ____Diabetes ____Asthma____Behavior Problems _____Anemia_____Sickle Cell____Bleeding Disorder _____Heart Problems____High Blood Pressure____Mental Disorder _____Seizures ____HIV/Aids ____Hepatitis ____Kidney Problems____Cancer
Allergies:_____
Are you currently taking any medication? Please list: _____
Hospitalization date(s), please describe problem: _____
Surgery date(s), please list reason for surgery: _____
Date of last dental visit: _____ List any current dental concerns:_____

Treatment provided may affect the future benefits that the resident receives under private insurance, Medicaid, or Medicare. For example, if you choose to participate in our program, then this will count as one of your regular dental exams.

RESIDENT/LEGAL RESPONSIBLE PARTY MUST READ AND SIGN BEFORE RECEIVING DENTAL CARE

I affirm that I am the resident or legal responsible party for the above named resident. I give permission for Smiles To Go, LLC to treat the resident and acknowledge that this form will become part of a permanent record that will be held in strict confidence. I verify that I have read this form and understand the privacy of health information (HIPAA).

Signature:_____ **Print Name:** _____

Date: _____

Note: This consent shall be considered in effect until rescinded or revoked.

Decline Services: I, _____, decline to participate in the Smiles To Go Dental Program.

PHOTO/VIDEO RELEASE FORM

I acknowledge that I am the resident or legal responsible party of the above named resident, and hereby grant permission to Smiles To Go (STG) and its employees the irrevocable and unrestricted rights to reproduce the photographs and/or video images taken of me, or members of my family, for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium. I hereby release STG and its legal representatives for all claims and liability relating to said images or videos. Furthermore, I grant permission to use my statements that were given during an interview or guest lecture with or without my name, for the purpose of advertising and publicity without restriction. I waive my right to any compensation.

____YES, I give permission for photos/videos to be taken of myself or the above named resident.

____NO, I do not give permission for photos/videos to be taken of myself or the above named resident.

HIPAA: CONFIDENTIAL PROTECTED HEALTH INFORMATION

STG's Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI) and describes your patient rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to review our notice before signing this consent form. You also reserve the right to revoke this consent, in writing, signed by you.

In signing this form, the resident/legal guardian understands that:

- PHI may be disclosed or used for treatment, payment, or health care operations.
- STG has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- STG reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their PHI, but STG does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- STG may condition receipt of treatment upon the execution of this Consent
- The patient acknowledges that he/she has received a copy of our HIPAA practices.

For a detailed, updated copy of STG's notice of privacy practices, visit our website at https://www.smiles2go.net or click here.

*****PLEASE ATTACH A COPY OF THE RESIDENT'S FACE SHEET, MEDICATION LIST, & DIAGNOSIS SHEET TO THIS FORM.**

We are excited and honored to be able to serve your residents!

Thank you,
Smiles To Go Doctors and Staff