Mobile Dentistry & Hygiene
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Authorization Form for Ongoing Prophy visits & Privacy Policy

I _____ consent for dental hygiene procedures to be provided for _____, of whom I am the responsible party. The care facility is _____. I understand that these services include a dental hygiene examination, periodontal screening, oral cancer examination, any necessary non-surgical periodontal scaling and/or an oral prophylaxis. I authorize oral prophylaxis (teeth cleaning) to be performed at the interval recommended by the hygienist/dentist without prior authorization for each visit.

I assume the payment responsibility for any services rendered. I understand that if insurance is billed, the insurance companies have frequency limits and I am responsible to understand those limits and will be billed for any visits that insurance doesn't cover. I will keep the residential facility informed of any changes in medical history that would indicate a need for prophylactic antibiotic treatment prior to dental hygiene treatment and allow them to administer said recommended medications. I understand an annual examination with a dentist is recommended. A Prime Mobile Dental Care dentist is available to do this exam upon my request. No treatment by a dentist will be performed without my prior authorization.

I agree to the sharing of all pertinent medical information from the facility to Prime Mobile Dental Care & Smiles All Around and any associated dentists/hygienists. This is to include any name(s), address(es), and phone number(s) that are part of the transaction of the delivering of the above dental hygiene services. A report of the rendered services and signed consent form will be kept in a confidential file by Prime Dental Care / Smiles All Around. A copy of the report services will be maintained in the resident's permanent record at the residential facility and can be sent to the responsible party upon request. No information will be shared or available to others unless in response to actions of law enforcement agencies, state insurance departments, subpoenas, or other court orders.

_____	_____	_____
Authorizing Signature	Relationship to Patient	Date