TRAVELING TOOTH FAIRY

PATRICIA CRAIG - RDHAP #255 **(916) 206-5000**
Registered Dental Hygienist in Alternative Practice

CONSENT FOR TREATMENT

Patient's Name: _ _ _____ _____Sex:__ _____

Patient's Home Address: _____
City, State, Zip: _____

Private Ph. #_____ Birthdate: _____E-mail _____

Name of Special Care Facility: _____ _____ Phone_____

Facility Address: _____ City, State, Zip: _____

Facility Contact Name:__ _____Title:_____

Name of Physician: ___ _____ Physician's Address: _____ _____
City, State, Zip: _____ _____ Physician's Phone:_____ _____
Kaiser # (if applicable) _____ Physician's Fax: _____

Name of Previous Dentist_____

Dentist's Address: _____ Dentist's Phone:_____
City, State, Zip: _____ Dentist's Fax: _____

Describe current or long-term disability/ medical condition/medications:

Please Circle all that apply:		High Blood Pressure	**No-Y**	Radiation Therapy	**No-Y**
Heart Murmur	**No-Y**	Mitral Valve Prolapse	**No-Y**	Cerebral Palsy	**No-Y**
Heart Pacemaker	**No-Y**	Hip/Joint Replacement	**No-Y**	Multiple Sclerosis	**No-Y**
Hemophilia	**No-Y**	Hepatitis	**No-Y**	Blindness	**No-Y**
H.I.V. Positive	**No-Y**	Epilepsy or Seizures	**No-Y**	Deaf	**No-Y**
Diabetes	**No-Y**	Stroke	**No-Y**	Parkinson's Disease	**No-Y**
Allergies	**No-Y**	Dementia	**No-Y**	Alzheimer's Disease	**No-Y**

Specify any Allergies:

Patient Trust accounts or Private Dental Insurance may be billed for Dental Hygiene Treatment. Permission is authorized for third-party (insurance) payment directly to **TTF SERVICES, (TRAVELING TOOTH FAIRY**). **All fees are ultimately the responsibility of the Responsible Party.** All fees are due at TIME OF SERVICE. All insurance billing will be sent via electronic bill, and payment will be sent directly to YOU, THE PATIENT. Be sure your address is recorded accurately!

Type of Billing: (please check) _____ Private Funds _____
____ Dental Insurance – Please see page 2 for insurance information

At this time (9/09) I am not taking
Medi-cal patient insurance.

Date of last cleaning: _____

PLEASE COMPLETE THE REMAINDER OF THIS FORM - PAGE 2. THANK YOU

Patient Name: _____ _____ Facility Name: _____
Name of Dental Insurance:
_____

Group Name: _____Group # _____ _____
Send Claims to (address): _____

Name of Primary Insured: _____Relationship to Patient: _____
Soc. Sec. # of Primary Insured: _____Birth Date of PrimaryInsured:_____

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

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 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 prior approval or to determine whether your plan will cover treatment.

NAME OF RESPONSIBLE PARTY: __ _____ Phone:_____
Please Print
Mailing/ Billing Address: _____

City, State, Zip: _ _____ Relationship to Patient: __ ___ _____

To whom can we thank for referring you to us: **Name:** _____

Permission Granted for Review of Medical Records.
An associate RDHAP may be the provider of mobile dental hygiene services.
Permission Granted to take pictures of patient for chart identification and educational purposes.

All fees are ultimately the responsibility of the "Responsible Party."

SIGNATURE OF RESPONSIBLE PARTY: ___ _____Date_____

SIGNATURE OF POWER OF ATTORNEY
(if applicable) FOR HEALTH CARE: _____ _____ Date:_____ __