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License # 588

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GERISMILES
A MOBILE DENTAL HYGIENE PRACTICE

CONSENT FOR TREATMENT

Patient's Name: _____ Sex: _____

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

Social Security #: _____ - _____ - _____ Birthdate: _____

Name of Special Care Facility: _____

Facility Address: _____ Phone: _____

Facility Contact Name: _____ Title: _____

Name of Physician: _____

Physician Address: _____ Physician's Phone: _____

Kaiser # (if applicable): _____ Physician's Fax: _____

Name of Dentist: _____

Dentist's Address: _____ Dentist's Phone: _____

Describe current or 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 or Seizures	Yes	No	Deaf	Yes	No
Allergies	Yes	No	Stroke	Yes	No	Parkinson's Disease	Yes	No
			Dementia	Yes	No	Alzheimer's Disease	Yes	No

Specify any Allergies:

Medi-Cal, Share-of-Cost Medi-Cal, Patient Trust accounts or Private Dental Insurance may be billed for Dental Hygiene Treatment. Permission is authorized for third-party (insurance) payment directly to Healthy Glo Dental Hygiene Practice. **All fees are ultimately the responsibility of the Responsible Party.** All invoices are due upon receipt.

Type of Billing: *(please check)* ◯ Private Funds ◯ Medi-Cal ID No. _____
◯ Dental Insurance – Please see page 2 for insurance information

Please attach copy of current Medi-Cal Benefits Identification Card **Medi-Cal Card Issue Date:** _____

Medi-Cal coverage for dental hygiene is usually once per full 12 month period. Special conditions and/or medications may determine more frequent treatment. Permission is granted to use Medi-Cal Share of Cost funds if available.

Date of last cleaning: _____

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