Medical/WIC Office Dental Hygiene Program Permission Form

Patient Consent & Medical/Dental History

P.O. Box 314 Lewiston, Maine 04243 • Office (207) 513-1111

* For appointment – Call Pat 603-767-7877

LOCATION OF CLINIC: **Curtis Lake Christian Church** DATE: Saturday June 11

If patient is being seen regularly **EVERY SIX (6) MONTHS** by a dental provider other than Tooth Protectors for either an exam by a dentist, a dental cleaning and fillings (if needed) DO NOT fill out this form as they do not qualify for these services.

Please COMPLETE ONE FORM per Patient – An incomplete form will result in patient NOT being seen.

GENERAL INFORMATION:

Patients Full Name: _____ Date of Birth: ____/____/_____ Male / Female

Mailing Address: _____ Town: _____ State_____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Emergency Contact (name & phone#): _____ Email Address: _____

All of the information listed above will be used by TPI to contact you regarding you or your child's present or future appointment

****If your Dental Insurance has changed from what TPI has on file, please provide the new information below.***

___ NEW DENTAL INSURANCE- Ins. Company Name: _____ Policy Holders Full Name: _____ DOB: _____

Group # _____ Policy/Subscriber ID#: _____ Dental Provider Phone# *(on back of Ins Card)* _____

Please present insurance card to Hygienist so a copy can be made.

___ SELF PAY PAYMENT METHOD: ☐*Check #*_____ ☐*Cash* ☐*Money Order* ☐*Credit Card*

- ✓ ***Cash, Check, or Money Order,*** In the exact amount
- ✓ **Please make Check/MO payable to:** *TPI or Tooth Protectors Inc.,* - **There will be a $25.00 fee for insufficient funds**
- ✓ **Please make out a Separate Check for Each Child being seen & write your child's Full Name in the Memo Line of your check**
- ✓ To pay by ***Credit Card,*** if you have not already made payment, please advise the Hygienist who will get you in touch with our office to provide payment information

Services I want my child to receive: ***(Check the services from left to right. Then add up & total to the right)***

☐ My child is age **1 to 12,** for	☐ **$55.00 - Full dental cleaning, Review**	☐ **Fluoride treatment $15.00**	☐ **Sealants $20.00** *per tooth*	*TOTAL:$*_____
☐ My child is age **13 to 100,** for	☐ **$65.00 - Full dental cleaning, Review**	☐ **Fluoride treatment $15.00**	☐ **Sealants $20.00** *per tooth*	*TOTAL:$*_____
☐ My child is age **1-100,** for	☐ **$30.00 - Review** of proper brushing, flossing and fluoride treatment.		☐ **Sealants $20.00** *per tooth*	*TOTAL:$*_____

MEDICAL/DENTAL HISTORY:

Has your child ever needed Antibiotics for dental treatment? Y N ***(if yes, please take the same precautions prior to treatment)***

Please list dental concerns you may have: _____

List any Medical Conditions/Allergies your child has: _____

List ALL Medications: _____ Physicians Name: _____

Has your child ever seen a Dentist? Y N Does your child take prescription Fluoride Supplements? Y N Do you have Town/City Drinking Water? Y N

Has he/she had a cleaning **in the past 6 months?** Y N If yes, was it at school? Y N Patient was last seen (*month & year*): _____

Patient last seen by (*if NOT last seen at school*): _____ Services received during **Last Visit:** *Cleaning—Fluoride—Sealant—Fillings—Exam—X-Ray Other:*_____

Dental Services you DO NOT want your child to receive from Tooth Protectors Inc. please list: _____

I give permission for myself or my child to receive dental services provided by licensed registered dental hygienist with Public Health Status (PHS). Tooth Protectors Inc. (TPI) may release basic information confirming myself or my child's services, for school screenings, dental offices, and others for the benefit of myself or child. I understand that the services provided do not take the place of an exam by a dentist. I understand that TPI is HIPAA compliant and all records are kept confidential and that claims to my insurance will go directly through TPI per electronic transfer. I also understand that all information that I have entered onto this permission form is accurate and truthful and understand that it is my responsibility to report/remember the patients dates of dental service and report dates when needed for current/future dental treatment and cannot hold TPI responsible if the information is not accurate/truthful on this form regarding current and/or previous treatment/appointments with other dental office locations. I understand that if I have listed insurance information for the patient & he/she does NOT have dental coverage at the time services are provided, and/or received the same services by another dental provider within 5 months and I did not divulged this above, than I assume all responsibility for payment of services received and understand that I will receive a bill from Tooth Protectors.

I UNDERSTAND THAT THE ABOVE PATIENT WILL HAVE A DENTAL CLEANING TODAY AND IS NOT DUE AGAIN FOR 6 MONTHS.

Signature of **Patient** or **Parent/Guardian:** _____ **Date:** _____

Printed Name of **Parent/Guardian:** _____ **Relationship:** _____