Physician-Based Program – Dental Screening/Services Consent

Select dental services are now being offered along with regularly scheduled medical visits (checkups) at HealthEast Roselawn Clinic! A collaborative practice dental hygienist will provide a dental screening, and/or teledental services for pregnant mothers, infants, and children to age 18. Services may include dental screening, x-rays, intraoral pictures, teledental exams, tooth/mouth care instructions, nutritional guidance, fluoride varnish and/or silver diamine fluoride application to strengthen teeth or slow cavities. Please complete and sign this form if you, or your child, would like to participate in this program.

You/your child should receive a dental exam at least once a year. Dental screening does not take the place of a dental examination.

Childs/Patients Name: _____ Patient/Child's Birthdate: _____

INSURANCE INFORMATION: Please check one of the boxes below. Payment from Minnesota Health Care Programs and other insurance plans helps to cover the cost of this program.

□ I am/My child is covered by Minnesota Health Care Programs. Circle the name of the insurance plan and fill in the ID numbers.

BluePlus | Metropolitan MHP Health Plan | HealthPartners | UCare | (MHCP) | MEDICA

ID #/Member # _____ PMI#(Health Partners/DentaQuest/UCare _____

□ I am/My child is covered by another dental insurance plan not listed above:

Plan Name_____ Policy Holder's Name_____

Policy holder's Birthdate_____ ID #/Member #_____

Group # _____ Insurance Phone # _____

CONSENT TO TREATMENT

I give Community Dental Care's Physician-Based Program permission to:

- provide a dental screening, teledental and/or preventive services for me/my child. (Services may include a dental screening or tele-dental exams, x-rays, intraoral images, tooth brush cleaning, mouth care instructions, nutritional guidance, application of fluoride varnish and/or silver diamine fluoride.)
- collect payment from Medical Assistance or private insurance
- allow the dentist to access my, or my child's, medical history and records and share dental exam records with physician/medical provider
- use dental records for treatment and billing purposes
- contact me to provide health care information about treatment, payment, my insurance, or my account.

By signing this form, I consent for me/my child to participate in the Community Dental Care Physician -Based Program. I have received a copy of Community Dental Care's Notice of Private Practices, and I am aware that a copy of the Notice of Privacy Practices is also available for me to view on the Community Dental Care website (cdentc.org). Consent is valid for 24 months to provide follow-up services.

Name of patient or parent/guardian (please print):_____

Signature of patient, parent/guardian _____Date_____

Emergency Contact Name: _____, Relationship to patient: _____, Phone: _____

If you have further questions about Community Dental Care's Physician-Based Program please contact Kate Iverson (651-925-8403 or kateanniverson@cdentc.org)

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Funding for this program was made possible by the generosity of individual donors, corporations, and grants from Minnesota Department of Health, Shavlik Foundation, Medica, and FR Bigelow Foundation.

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Time in: _____ Time out: _____
Medical History:

- *Allergies_____*
- *Medications_____*
- *Health/Medical Problems_____*

Race/ethnicity: _____
Preferred language: _____

Home Care:

- *Brushing teeth? YES/NO how often ___X/Day;*
- *Parent assists with brushing? YES/NO*
- *Flossing? YES/NO frequency _____x/week*
- *Fluoride toothpaste used? YES/NO*

Dental Home/ Hx:

- *Have you/your child visited the dentist before today? YES/NO*
  - *Date of last dental visit? _____*
- *Parents/primary caregiver has regular dental visits? YES/NO*
  - *Last dental visit for caregiver? _____*
  - *Parent has decay? YES/NO*

Eating/Feeding habits:

- *Takes Bottle or sippy cup to bed? (in bed or unlimited access) YES/NO*
- *What do you/your child drink between meals?*
- *Snacking habits <3 snacks/day ; 3or > snack/day ; unlimited access to sweet drinks/foods*
- *Family uses tap water? YES/NO … or Bottled water? YES/NO*

Pregnant mothers

- *due date:_____; dental history_____; referral_____*

Chief Concern:

_____
_____

_____

OFFICE USE BELOW LINE
Interpreter Name:

- *Time in:*
- *Time out:*

Teeth present:

Referral:

SDF offered?

- *Tooth #s:*

Notes:

Appointment assistance:

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