MAY BOSCO PRACTICE OF DENTAL HYGIENE
May Bosco, RDHAP, B.S.
Registered Dental Hygienist in Alternative Practice
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CONSENT FOR TREATMENT

Patient's Name: _____Sex:_____

Patient's Home Address: _____

City, State, Zip: _____

Social Security #: _____-_____-_____ Birth date: _____

Address _____

City_____, State_____, Zip: _____

Phone: _____

Primary Contact Person:_____Title:_____

Name of Physician: _____ Physician's Address: _____

City, State, Zip: _____ Physician's Phone: _____

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

Name of Dentist_____

Dentist's Address: _____

Dentist's Phone: _____ Dentist's Fax: _____

Describe current or long-term disability/ medical condition: Please circle that apply to patients

Please Circle all that apply:			High/Low Blood Pressure	**Yes**	**No**	Radiation Therapy	**Yes**	**No**
Heart Murmur	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**	Cerebral Palsy	**Yes**	**No**
Heart Pacemaker	**Yes**	**No**	Hip/Joint Replacement	**Yes**	**No**	Multiple Sclerosis	**Yes**	**No**
Hemophilia	**Yes**	**No**	Hepatitis	**Yes**	**No**	Blindness	**Yes**	**No**
Dementia	**Yes**	**No**	Epilepsy or Seizures	**Yes**	**No**	Deaf	**Yes**	**No**
Diabetes	**Yes**	**No**	Stroke	**Yes**	**No**	Parkinson's Disease	**Yes**	**No**
Allergies	**Yes**	**No**	Alzheimer's Disease	**Yes**	**No**	HIV/AIDS	**Yes**	**No**

Specify any Allergies:

Date of last cleaning: _____

_____

Signature of Patient **Date**

IF THE PATIENT IS UNDER THE AGE OF 18 OF AGE or UNDER SUPERVISION OF CONSERVATOR

As the guardian of _____, I, _____,
Print Name of Patient **Print Name of Guardian/Conservator**

Consent to treatment and the validity of the given information.

_____

Signature of Guardian **Date**

Insurance Information

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 or Primary Insured ID #: _____
Birth Date of Primary Insured _____

Dental Insurance Phone Number (for eligibility and claim information): _____
May H. Bosco will send the dental service claim to the above provided insurance company behalf of the patient for courtesy, and the insurance will reimburse the insured member directly. All fees are ultimately the responsibility of the Responsible Party and all the hygiene service fees are paid directly to May H. Bosco. All fees are due in 30 days from date of invoice. After 30 days, a $10 per month ReBill/ Late Fee will be assessed.

Type of Billing: (please check) ____ Private Funds (self pay) _____ Dental Insurance

All Information regarding dental insurance is necessary if you need. If information is not complete, treatment may be delayed or.

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

Fax: _____

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 FOR HEALTH CARE: _____ Date:_____