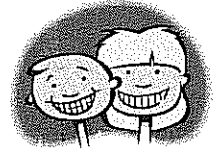


# Healthy Smiles, Happy Kids

## Mobile Dental Van

### CONSENT FOR DENTAL TREATMENT



Please Print and Complete this Form in INK

This Consent form and the Patient Information and Health History Must be returned before dental services will be scheduled for your child. A new consent and health history must be completed for all patients (new or existing) enrolled in dental van program. A written report of services provided will be sent home with your child following each appointment on the Mobile Dental Van. If you have any questions, please call: Dr. Sheila A. Smith, DMD at (610)377-7354 or (484) 464-5656.

I authorize the dental staff to provide dental services for my child. Routine treatment will include an examination by a licensed dental professional and may include x-rays, cleaning, sealants, topical fluoride, injection of a numbing agent (local anesthesia) and dental fillings. I understand that the risks of dental treatment are uncommon but could occur. These risks include: infection, continued numbness or tissue irritation from local anesthetic, inhalation of a foreign body, accidental cut, soreness, pain, swelling, and allergic reaction to numbing agent. I understand that it is my responsibility to notify the Dental Staff of any changes in my child's health, medications, or insurance coverage and that I may withdraw consent at any time.

I authorize the dental staff to bill my insurance provider for services rendered. For dental services provided to MA recipients the payment and satisfaction of the claim submitted by the provider of the services will be from Federal and State funds. I understand that any false claims, statements, documents, or concealment of material facts may be prosecuted under applicable Federal and State laws.

Medical Assistance Coverage:

Geisinger ID # \_\_\_\_\_  
 Ameri-Health ID # \_\_\_\_\_  
 Aetna Better Health ID # \_\_\_\_\_

My child is covered under private insurance in addition to Medical Assistance coverage

Insurance Co. Name \_\_\_\_\_ Policy # \_\_\_\_\_

I have had the opportunity to ask questions about the above information, clinic procedure and treatment and these questions have been answered to my satisfaction.

Full Name of Child (please print) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Social Security Number: \_\_\_\_\_ Existing dental van patient: \_\_\_\_\_ New Patient \_\_\_\_\_

Full Name of Parent/Legal Guardian (please print) \_\_\_\_\_

Parent/Legal Guardian SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

#### Notice of Privacy Practices Patient Acknowledgement Form

Our Notice of Privacy provides information about how we use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our privacy officer at 610.377.7063 or viewing a copy of the Notice of Privacy Practices at [www.blmtn.org/contents/privacystatement.htm](http://www.blmtn.org/contents/privacystatement.htm).

You have the right to request we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that you agree with our notice of use and disclosure of protected health information about your child's treatment, payment and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_