

# CONSENT FORM

## DENTAL SERVICE

Phone: 587-834-2206



Dental oral health service **ON-SITE** for seniors living in assisted living or nursing homes. This service provides oral care for those with teeth or with dentures. Service is provided by Dental Hygiene Connections – Mobile care by Lyba Aulakh, Registered Dental Hygienist.

**It is best to email or fax your completed form to: dhccmobile@gmail.com** You can also leave your completed form at the front RECEPTION desk. Please feel free to call us if you have any questions. **You will be contacted to book an appointment ONCE we have received the form. PLEASE call us if you have NOT heard from us within 1 week of submitting your form.**

Unfortunately, due to providing services in those that are elderly we may not always be able to completely remove all the tartar deposits on the teeth. This is due to a number of factors such as wheelchair dependent clients (access limitations), medical conditions such as dementia, Parkinson's etc (not being able to sit for long periods of time). We are committed to doing our utmost to provide the best care possible. This may mean more frequent recall intervals for our seniors due to HIGH CAVITY risk due to a number of factors. We RESPECT your right of choice and our recall intervals is our professional opinion based on the residents oral health status. We will honor whatever your decision is.

**Date:** \_\_\_\_\_ **Facility:** BOW VIEW MANOR **Room #** \_\_\_\_\_

**Resident Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Dental Insurance:** YES / NO

**Insurance Company:** \_\_\_\_\_ **Policy #** \_\_\_\_\_

**Certificate or ID #** \_\_\_\_\_

### **CONTACT INFORMATION: (Power of Attorney)**

**Note: Any changes in Power of Attorney MUST be done in writing to us, otherwise we will continue to send the oral reports and billing to what is filled out in this form.**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
Province

\_\_\_\_\_  
Postal Code

\_\_\_\_\_  
Home or Cell Phone

\_\_\_\_\_  
Email Address

**Circle One:**

- x I give permission for oral health services “Teeth Cleaning” on an on-going basis. Includes: New client exam, digital x-rays if required, scaling, root planing, polishing and fluoride.
- x Denture Clients: I give permission for yearly denture exam, cleaning and labeling of dentures on a regular on-going basis.

A copy of the dental oral report and dental insurance statement will either be emailed OR mailed to you. I understand that IF I provide my email for sending oral reports to me, is not 100% safe. Dental Hygiene Connections will make reasonable efforts to send your reports via HUSHMAIL and encrypted to secure information being sent to you as a secure source.

Due to recent legislation, you are covered under the Privacy Act; please view our privacy policy online at [www.healthyteeth4life.ca](http://www.healthyteeth4life.ca) under MOBILE tab. Dental information through your insurance provider may be deemed confidential and may not be released to our office. I understand that I am personally responsible for payment of dental services rendered. I authorize the dental staff to perform such dental services as deemed necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company for legal documentation. I hereby consent to submit any insurance claim electronically, if permitted by the insurance carrier. I have read the above conditions of treatment and agree to their content.

**Our mission is to help our seniors achieve optimal oral health and we stay WITHIN the senior fee guides for Alberta! This helps to keep out of pocket expenses to a minimum. Any suggestions in improvement for our services is greatly appreciated :)**

\_\_\_\_\_

Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date