PROGRAM BENEFITS

All patients will receive an oral health screening, cleaning and oral hygiene instruction by the dental provider.

Some patients may need to be scheduled for further dental treatment and will be referred to either the Martha's Vineyard Hospital Dental Center or a dentist from Commonwealth Mobile Oral Health Services.

Referrals are dependent on the extent of the dental disease.

Consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your dental treatment. Most patients do not encounter any difficulties with their treatment. In rare instances, a patient may experience some discomfort or pain. If the patient indicates any resistance to the dental procedure, we would discontinue the treatment.

CONTACT INFORMATION:

CMOHS: Rachel Unwin (508) 947-0111
email: r.unwin@comcast.net

Polished: Ellen Gould RDH (508) 237-5378
gould.ellen@gmail.com

Vineyard Smiles: Sarah Kuh
(508) 696-0020 x11
skuh@vineyardhealthaccess.org

By signing this form, I am giving consent to receive dental treatment.

1) I understand that dental treatment may include any or all of the following: Dental Exam and Diagnosis, X-Rays, Dental Cleaning, Fluoride, Oral Hygiene Instruction, Fillings, Other Restorative Dentistry, Prosthetics, Prosthodontics, and Recall Visits.
2) I also understand that some dental treatments may require the possible application of local anesthetic xylocaine or "novocaine."
3) I understand it is my responsibility to inform the dental provider of any changes in my medical history and insurance information.
4) I understand that my health information may be used for treatment, payment and health care operations.
5) If I have dental insurance, I authorize my insurance carrier to be billed for any services provided by CMOHS or Polished.
6) I understand that I may continue to obtain dental care though any other provider.
7) I understand that treatment provided may affect future rights and benefits of private insurance or Medicaid.

I have read and understand this consent form and I authorize the dental program to provide a written summary to participating providers as needed. I consent to participate.

Signature: _____

Printed Name: _____

Date:_____

CMOHS
COMMONWEALTH
Mobile Oral Health Services

clean teeth Polished good health

VINEYARD SMILES
Improving oral health on Martha's Vineyard

Are partnering to provide dental services to you.

These services may include:

- ♦ Routine Dental Screenings & Exams
- ♦ Diagnosis
- ♦ Dental X-Rays
- ♦ Dental Cleanings
- ♦ Fluoride Treatment
- ♦ Restorative Dentistry (*fillings*)
- ♦ Prosthetics including crowns & bridges
- ♦ Prosthodontics including full & partial dentures
- ♦ Oral Hygiene Instruction
- ♦ Recall Visits (*Continuous Care*)

PLEASE SIGN OTHER SIDE!

PATIENT INFORMATION

Please be sure to complete all sections.

Last Name First Name

Address: Number Street Apt.

City State Zip

____/____/ - ____/____/ - ____/____/____/____

Date of Birth *(month / day / year)*

____/ ____/ ____/- ____/____/-____/____/____/____

Social Security Number (optional)

Gender: Female _____ Male_____

___/___/___/ - ___/___/___/ - ___/___/___/___

Home Phone

___/___/___/ -___/___/___/ - ___/___/___/___

Cell Phone

Have you been to the dentist in the past year?
yes _____ no_____ If **yes,** dentist name:

Race: Please check all that apply *(Optional)*
☐1 White; ☐2 Black/African American
☐3 Asian; ☐4 Native Hawaiian/Pacific Islander
☐5 American Indian/Alaska Native;
☐6 Hispanic; ☐7 Unknown; ☐9 Other

DENTAL INSURANCE

Please have a copy of your MassHealth or Private Dental Insurance Cards (not.Medicare) so we can bill your insurance company for the dental services.

___ I have no dental insurance and will be personally responsible to pay my bills. I understand a sliding fee scale may be made available to me to defray some of the costs.

__ I have insurance and the information is listed below.

Medicaid or Private Insurance
Dental Insurance
Please note we Do Not Accept Medicare

Insurance Company Name

Employer Name if applicable

Subscriber's Name

___/___/ - ___/___/ -___/___/___/___

Subscriber's Date of Birth *(month / day / year)*

___/___/___/-___/___/-___/___/___/___

Subscriber's Social Security Number

Subscriber's ID

Group Policy Number

MEDICAL INFORMATION

Please be sure to complete all sections.

Physician's Name

Physician's Address

___/___/___/ - ___/___/___/ - ___/___/___/___

Physician's Phone

Do you have any **allergies**?
yes _____ no_____
If **yes**, please check all that apply: ☐Antibiotics, ☐Colophonium, ☐Foods, ☐Latex, ☐Penicillin, ☐Resins, ☐Medications (list)_____
☐Other: _____

Do you need **antibiotics** before dental treatment? yes _____ no_____ If **yes**, please explain: _____

Do you take **medications** on a routine basis?
yes _____ no_____ If **yes**, please list:
_____
_____
_____
_____
_____

Have you ever had any of the following?

YES	NO	YES	NO
☐	☐AIDS/ARC/HIV	☐	☐Asthma
☐	☐Birth Defects	☐	☐Blood Disorders
☐	☐Cytomegalovirus	☐	☐Congenital Heart Disease
☐	☐Diabetes	☐	☐Epilepsy/Seizures
☐	☐Fainting Spells	☐	☐Heart Disease
☐	☐Hepatitis	☐	☐Heart Murmur
☐	☐Herpes	☐	☐High Blood Pressure
☐	☐Rheumatic Fever	☐	☐Kidney Disorder
☐	☐Tuberculosis	☐	☐Pins/Broken Bones
☐	☐Venereal Disease	☐	☐Stomach/GI Disorder
☐	☐Other: _____		