SCHOOL-BASED/MOBILE DENTAL PROGRAM

(203)696-3270

Consent, Release, and Acknowledgement

Student's Name:_____ D.O.B.: _____

Please Read the Following Statements	Initials
Because the patient is a minor, it is necessary that signed permission be obtained from a parent or guardian before dental care can be provided. Igive pernission for my child to obtain all services offered by the Optimus Health Care, Inc.- School Based / Mobile Dental Program. **Authorization for** care: Your Signature permits us to perform the following procedures as part of routine care provided to your child: Cleaning of teeth and application of fluoride varnish, sealants, X-rays of teeth, cavity repair/filling, local anesthesia Septocaine/Lidocaine/Carbocaine and tooth extractions, if necessary. I understand that all the services provided to my child are confidential except in life-threatening emergency situations and In accordance with the law. Indicate a procedure you request to be notified in advance for: _____	
I authorize the release of health information in the school health record to Optimus Health Care, Inc. -School Based/Mobile Dental Program staff. I give the Dental Clinic staff permisssion to communicate with the school nurse and forward health information to ensure the best care for my child. The permission form can be rescinded in writing at any time.	
I give my consent to allow a representative of the Optimus Health Care, Inc.- School Based/Mobile Dental Program to call my child out of class to the Dental Clinic for appointments.	
I authorize Optimus Health Care, Inc.- School Based Dental Program to bill my insurance carrier for any covered services. I give permission for the release of information to my insurance company regarding treatment of services for the purpose of billng. I authorize Insurance payments to be made directly to Optimus Health Care, Inc.- School Based Dental Program for services provided.	
I understand that the information I have given is correct to the best of my knowledge, that if will be held in strict confidence and it is my responsibility to inform the office of any changes in my child's medical status and my child's dental insurance. I have read and received a copy this office's financial policy and Iagree with the terms and conditions of that document. I understand that after one billing cycle, I am responsible for all changes of services provided to my child for the Optimus Health Care, Inc.- School Based/Mobile Dental Program.	
In the event your child has a dental emergency call the Optimus Health Care, Inc. at 203-696-3270. If this is a true emergency and we can not be contacted, please take your child to the nearest Emergency Room.	

Have there been any **changes** with your child's **medical history** in the last **12 months**? Y/N

If yes, what are the changes that have occurred:

I acknowledge that I have received a copy of the "Privacy Notice" for the Dental Program and understand that I may contact Optimus health Care, Inc. at 203-696-3270 if I have any questions about the content. I understand that this consent is valid for 1 year from the date signed.

Parent/Guadian Name: _____ Date: _____

Parent/Gaurdian Signature:_____

Phone Number:_____