

## **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](mailto:r.unwin@comcast.net)

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

**Vineyard Smiles:** Sarah Kuh  
(508) 696-0020 x11  
[skuh@mvhealthcareaccess.org](mailto:skuh@mvhealthcareaccess.org)

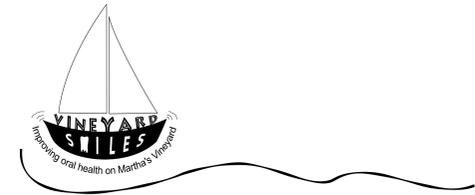
*By signing this form, I am giving consent to receive dental treatment.*

- 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:** \_\_\_\_\_



*Joining forces to provide dental services to seniors in Dukes County.*

## **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
<input type="checkbox"/>	<input type="checkbox"/> AIDS/ARC/HIV	<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Birth Defects	<input type="checkbox"/>	<input type="checkbox"/> Blood Disorders
<input type="checkbox"/>	<input type="checkbox"/> Cytomegalovirus	<input type="checkbox"/>	<input type="checkbox"/> Congenital Heart Disease
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/> Heart Disease
<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/> Herpes	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorder
<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/> Pins/Broken Bones
<input type="checkbox"/>	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/> Stomach/GI Disorder

Other: \_\_\_\_\_