[PRACTICE NAME]

Collaborative Care Consent Form

[PRACTICE NAME] is offering [services] at __________[location]___________________.

Benefits:

- **Oral screenings** provide a quick and easy way to see if you have any obvious dental issues that need care. An oral screening does not replace a complete dental exam. The patient should visit the dentist for a complete exam every 6 months.
- **Dental sealants** are thin, plastic coatings that are painted on the chewing surfaces of the permanent back (molar) teeth to prevent cavities. Sealants can help prevent or delay cavities.
- **Fluoride** helps strengthen teeth and prevent cavities. Fluoride varnish can be applied 2 to 4 times per year.
- **[Add benefits for additional services, as needed]**

Risks & Alternatives:

- **Oral screenings** have minimal risk. A light may be used to see into the mouth; patients with light sensitivity should report the condition to their provider. Alternatives to screenings include full dental exams, including X-rays.
- **Dental sealants** have minimal risk. The process of applying sealants may cause temporary sensitivity in tissues in the mouth (like tongue, cheek, gums or teeth). It is possible for sealants to loosen over time; brushing and flossing regularly and chewing healthy foods may help sealants last longer. A light may be used to see into the mouth; patients with light sensitivity should report the condition to their provider. Although there is no exact alternative to dental sealants, other preventive habits like brushing, flossing, visiting a dentist, fluoride application, and eating healthy foods may prevent cavities as well.
- **Fluoride** has minimal risk. A light may be used to see into the mouth; patients with light sensitivity should report the condition to their provider. Alternatives to fluoride varnish include other preventive habits like brushing, flossing, visiting a dentist and eating healthy foods.
- **[Add risks & alternatives for additional services, as needed]**

[Should you wish to collect insurance information, tailor the information below]:

Does the patient have insurance? Yes No
If yes, please provide the insurance information below:

Insurance Company: ____

Policy Number: __________________________ **Group Number:** __________________________

Insured's Name: _____________________ **Insured's Relationship to the patient:** _____________

Insurance Company Address: ____

Insurance Company Phone Number: ____

1. **Has the patient had dental care in the past twelve months?** Yes No
2. **Does the patient have an appointment scheduled at the dental home where care is normally provided?** Yes No
    a. If *yes,* please list the name and address of the dentist or dental home where the care is provided.
    ____
    If yes, we recommend seeing your usual dentist instead of participating in this clinic.

CONSENT TO TREATMENT

Signing this form gives permission to **1)** screen and perform dental services under a Dental Hygiene Collaborative Care Permit with [CONSULTING DENTIST] performing record review; **2)** seek reimbursement from any insurance you may have; **3)** and provide some background information on the patient. You will get a document to inform you of screening results, services provided, and a dental referral, if needed.

I understand that I can choose to have dental hygiene services provided at the dental home where care is normally provided rather than a public setting. I understand that all dental hygiene care provided by the dental home I have used in the past or by a collaborative care dental hygienist will reduce future benefits that the patient may receive from private insurance, Medicaid (ARKids), or other third-party providers of dental hygiene benefits for the remaining benefit period.

Patient Name: ____

Patient DOB: ____________________

Parent/Guardian Name (please print): ____

Parent/Guardian Signature: ____

Date: _________________

Consulting Dentist:
Arkansas Dentist License Number:
Address:
Phone:

Dental Hygienist:
Arkansas Dental Hygienist License Number:
Address:
Phone: