

The ***Request for Consultation Form*** must be approved by your medical doctor (not your dentist) before I can see you.

If you need me to facilitate that approval I am happy to help you.

I will need you doctors name and number as well as your birth date.

If you have any questions, my number is

206-948-7355
Deb Fredrikson

SMILES FOR LIFE

Senior Dental Access Programs

In 2000, Former U.S. Surgeon General Everett Koop warned the American public, "You can't be healthy without oral health". His landmark report, Oral Health in America, pointed to the lack of access to dental care for seniors who are on fixed incomes and lack dental insurance. The Smiles for Life Project aims to improve access to affordable dental care by empowering seniors with oral health and consumer education, dental and oral cancer screenings, affordable and convenient preventive services provided by licensed dental hygienists, personalized oral hygiene instructions, and financial and referral counseling – all provided at senior centers where other health and wellness services are provided to seniors.

In this packet you will find a set of forms that will need to be filled out and returned in order to qualify for the Smiles for Life programs. Ask if you need help filling them out. Attending one of our educational classes is free, but required to qualify for this program.

Below is a checklist to help guide you to complete the application process:

_____ Take the Request for Consultation form with the latest American Heart Association recommendations attached to your primary (medical) care provider, and ask them to fill it out, sign and date it. Bring this form with you, or ask your provider to fax the top form only to Dental Hygienics at 206-420-4999. By Law, this form must be returned to us in order to provide any services to you.

_____ Fill out the Dental-Medical History

_____ Complete, Sign and Date the Authorization for Dental Hygiene Services

_____ Complete, Sign and Date the HIPAA confidentiality form

_____ Complete the Financial Statement only if you think you might qualify for Medicaid or a discount program available to seniors with very low income. Please bring this form with a copy of your most recent Medical coupon, to your first appointment with us.

When we receive the faxed form from your medical provider, we will call you to make an appointment. If your provider gives the signed form back to you, please give us a call to schedule, and bring that form with the rest of your completed forms to your first appointment with us. Thank you!

Dental Hygienics

7683 SE 27th #441, Mercer Island, WA 98040
206-948-7355 Fax: 206-420-4999

Request for Consultation

Primary Care Provider: _____

Regarding Client: _____ Date of Birth: _____

Client's phone number: _____ Date of Request: _____

The Client or their Guardian has requested dental hygiene treatment. The treatment will involve initial evaluations, oral infection control through removal of bacterial debris by scaling and root debridement, and application of topical fluorides for caries prevention, as needed. The scaling and debridement are likely to cause gingival bleeding, transient bacteriemia and concern for persons who receive anticoagulants. Topical anesthetic and oral rinses may be used. Appointments are scheduled 30 to 45 minutes in length. Follow-up appointments will be scheduled as needed with the consent of the Client or Guardian. The Client will be referred to their dentist of record for comprehensive dental services.

Please complete the following orders by circling response

Client may have dental hygiene services as needed. **Yes No**
Comment: _____

Client requires Antibiotic pre-medication. **Yes No**
Rx: _____

Comment: _____
Other: _____ **Yes No**

Rx: _____
Comment: _____

Please rank the level of risk to this client **LOW MEDIUM HIGH**
for dental treatment including anesthetic injections

Comments: _____

Primary Care Provider Signature

Date _____

**PLEASE FAX COMPLETED TO THE DENTAL HYGIENICS
FAX NUMBER, LISTED ABOVE, OR GIVE A COPY TO THE CLIENT,
KEEPING A COPY WITH YOUR CLIENT'S MEDICAL RECORDS.**

Bacterial Endocarditis

What is bacterial endocarditis?

Bacterial endocarditis is an infection of the heart's inner lining (endocardium) or the heart valves. This can damage or even destroy your heart valves.

How does it occur?

Bacterial endocarditis occurs when bacteria in the bloodstream (bacteremia) lodge on abnormal heart valves or other damaged heart tissue. Certain bacteria normally live on parts of your body, such as the mouth and upper respiratory system, the intestinal and urinary tracts, and the skin. Some surgical and dental procedures cause a brief bacteremia. Bacteremia is common after many invasive procedures, but only certain bacteria commonly cause endocarditis.

Who is at risk?

Endocarditis rarely occurs in people with normal hearts. However, if you have certain preexisting heart conditions, you're at increased risk for endocarditis. Some of these conditions include having...

- an artificial (prosthetic) heart valve
- a history of previous endocarditis
- heart valves damaged (scarred) by conditions such as rheumatic fever
- various kinds of congenital heart defects
- hypertrophic cardiomyopathy (hi"per-TRO'fik kar"de-o-mi-OP'ah-the)
- people who have had a heart transplant who develop a heart valve abnormality

Some congenital heart defects, including a ventricular septal defect, an atrial septal defect, or a patent ductus arteriosus, can be successfully repaired surgically. After this you'll no longer be at increased risk for endocarditis.

Although endocarditis is a very serious disease, and many people may be at increased risk for developing it, most of these people do not contract it. According to the American Heart Association, there are about 29,000 cases of endocarditis diagnosed a year.

Updated recommendations published Aug. 1, 2007 in the American Heart Association Journal

"The major changes in the updated recommendations include the following:

(1) The Committee concluded that only an extremely small number of cases of infective endocarditis might be prevented by antibiotic prophylaxis for dental procedures even if such prophylactic therapy were 100% effective.

(2) Infective endocarditis prophylaxis for dental procedures should be recommended only for patients with underlying cardiac conditions associated with the highest risk of adverse outcome from infective endocarditis.

(3) For patients with these underlying cardiac conditions, prophylaxis is recommended for all dental procedures that involve manipulation of gingival tissue or the periapical region of teeth or perforation of the oral mucosa.

(4) Prophylaxis is not recommended based solely on an increased lifetime risk of acquisition of infective endocarditis.

(5) Administration of antibiotics solely to prevent endocarditis is not recommended for patients who undergo a genitourinary or gastrointestinal tract procedure.

These changes are intended to define more clearly when infective endocarditis prophylaxis is or is not recommended and to provide more uniform and consistent global recommendations. (Circulation. 2007;115:NA;-)

Endocarditis is much more likely to result from frequent exposure to random bacteremias associated with daily activities than from bacteremia caused by a dental, gastrointestinal (GI) tract, or genitourinary (GU) tract procedure. Prophylaxis may prevent an exceedingly small number of cases of endocarditis, if any, in individuals who undergo a dental, GI tract, or GU tract procedure.

The risk of antibiotic-associated adverse events exceeds the benefit, if any, from prophylactic antibiotic therapy. Maintenance of optimal oral health and hygiene may reduce the incidence of bacteremia from daily activities and is more important than prophylactic antibiotics for a dental procedure to reduce the risk of endocarditis.

Endocarditis prophylaxis recommended

Dental extractions

Periodontal procedures including surgery, scaling and root planing, probing, and recall maintenance

Dental implant placement and reimplantation of avulsed teeth

Endodontic (root canal) instrumentation or surgery beyond the apex

Subgingival placement of antibiotic fibers or strips

Initial placement of orthodontic bands but not brackets

Intraligamentary local anesthetic injections

Prophylactic cleaning of teeth or implants where bleeding is anticipated

Endocarditis prophylaxis not recommended

Restorative dentistry (operative and prosthodontic) with or without retraction cord

Local anesthetic injections (nonintraaligamentary)

Intracanal endodontic treatment; post placement and buildup

Placement of removable prosthodontic or orthodontic appliances

Taking of oral impression

Fluoride treatments

Taking of oral radiographs

Orthodontic appliance adjustment

Shedding of primary teeth

Prosthetic Joint Replacement Prophylaxis

Not routinely indicated for most dental patients. May be considered for patients with a potential increased risk of joint infection. High risk patients to consider for coverage include:

- Patients receiving corticosteroid therapy
- Immunocompromised/immunosuppressed patients
- Rheumatoid arthritis, systemic lupus erythematosus
- Hemophilia

- Insulin dependent diabetes
- First 2 years following joint replacement
- Previous joint infection
- Malnourished state
- Not indicated for patients with pins, plates or screws

Regimens Recommended

An antibiotic for prophylaxis should be administered in a single dose, 30 to 60 minutes before the procedure, 2 grams are recommended for adults and 50 mg/kg recommended for children. If the dosage of antibiotic is inadvertently not administered before the procedure, the dosage may be administered up to 2 hours after the procedure. However, administration of the dosage after the procedure should be considered only when the patient did not receive a pre-procedure dose.

Amoxicillin is the preferred choice for oral therapy because it is well absorbed in the GI tract and provides high and sustained serum concentrations. For individuals who are allergic to penicillins or amoxicillin, the use of cephalexin or another first-generation oral cephalosporin, clindamycin, azithromycin, or clarithromycin is recommended.

MEDICAL HISTORY

DATE _____

PATIENT'S NAME _____

1. Are you under the care of a physician at this time? YES NO
If yes, for what condition? _____
2. Have you been treated by a physician in the past six months? YES NO
If yes, for what condition? _____
3. Physician's Name: _____ Telephone: _____
4. Have you been hospitalized in the last 6 months? YES NO
5. Have you had any surgeries in the last 2 years? YES NO
If yes, please list: _____
6. Are you allergic or sensitive to any medicines or drugs? YES NO
If yes, please list: _____
7. Do you have or have you ever had any of the following?

PLEASE CIRCLE "YES" OR "NO" TO ALL QUESTIONS

- | | | | |
|---|--------|--------------------------------|--------|
| A Asthma, lung or other respiratory condition (s) | YES NO | N Diabetes | YES NO |
| B Alcoholism/drug addiction | YES NO | O Epilepsy/seizures | YES NO |
| C Allergies or hives | YES NO | P Hepatitis/jaundice A, B, C | YES NO |
| D Anemia | YES NO | Q HIV/AIDS | YES NO |
| E Artificial joint | YES NO | R Kidney/renal disease | YES NO |
| F Arthritis/rheumatism | YES NO | S Latex allergy | YES NO |
| G Cancer treatment/chemo | YES NO | T Rheumatic/scarlet fever | YES NO |
| H Heart condition | YES NO | U Sexually transmitted disease | YES NO |
| I Artificial heart valve | YES NO | V Stroke | YES NO |
| J Heart murmur or valve prolapse | YES NO | W Thyroid disease | YES NO |
| K Pacemaker/ defibrillator | YES NO | X Tuberculosis | YES NO |
| L Prolonged bleeding | YES NO | Y Herpes | YES NO |
| M High blood pressure | YES NO | Z Other: _____ | YES NO |

8. Are you taking any of the following?

- | | | | |
|-----------------------------------|--------|----------------------------------|--------|
| A Antibiotics | YES NO | F High blood pressure medication | YES NO |
| B Anticoagulants (blood thinners) | YES NO | G Insulin or similar | YES NO |
| C Antidepressants | YES NO | H Hormones | YES NO |
| D Aspirin | YES NO | I Steroids | YES NO |
| E Heart medications | YES NO | J Tranquilizers | YES NO |

8. Please list or attach a list of all current medications, vitamins or herbs: _____

10. Do you have any disease, condition or problem not listed above that we should know about?

If so, explain: _____

11. Do you now or have you ever used tobacco products? YES NO Currently? YES NO

If currently, list the type: _____ Amount per day: _____

12. Have you ever taken bisphosphonates? (Fosamax, Actonel, Boniva, Aredia, Zometa) YES NO

How long have you taken this medication? _____

13. Have you taken a pre-medication for dental treatment? YES NO What med? _____

PERSONAL INFORMATION AND DENTAL HISTORY

Patient Name _____	Today's Date _____
Date of Birth _____ SS# _____	Sex M F
Address _____	
City _____	ZIP _____
Telephone: home: () _____ cell: _____	
In case of emergency, please notify: Name _____	
Relationship _____	Telephone () _____

Do you have a current dentist of record? YES NO

Dentist's Name _____
 City _____ Telephone () _____

Date Of Last Exam _____ Did your visit include X-rays? YES NO

Date of Last Cleaning _____ By whom? Dentist Dental Hygienist Assistant

Do You Have Any Dental Problems Now? YES NO

If yes, please describe _____

Has it been difficult for you to receive dental care? YES NO

Please explain _____

Are any of your teeth sensitive to:

- | | | |
|---|-----|----|
| Hot or Cold? | YES | NO |
| Sweets? | YES | NO |
| Biting or Chewing? | YES | NO |
| Have you noticed any mouth odors or bad tastes? | YES | NO |
| Do you frequently get cold sores, blisters or any other oral lesions? | YES | NO |
| Do you have sinus infections? | YES | NO |
| Do your gums bleed or hurt? | YES | NO |
| Have you experienced gum disease or tooth loss? | YES | NO |
| Have you noticed any loose teeth or change in your bite? | YES | NO |
| Does food tend to become caught in between your teeth? | YES | NO |
| Do You: Clench or grind your teeth while awake or asleep? | YES | NO |
| Bite your lips or cheeks regularly? | YES | NO |
| Hold foreign objects with your teeth? (pen, pipe, pins, nails, fingernails) | YES | NO |
| Have tired jaws or sensitive teeth, especially in the morning? | YES | NO |
| Smoke/chew tobacco? | YES | NO |

Have you ever had:

- | | | |
|---|-----|----|
| Orthodontic treatment? | YES | NO |
| Oral surgery? | YES | NO |
| Periodontal/gum disease treatment? | YES | NO |
| Your bite adjusted or teeth ground? | YES | NO |
| A mouth guard or night/bite guard? | YES | NO |
| A serious mouth or head injury? | YES | NO |
| If so, please describe, including cause _____ | | |

Have you experienced:

- | | | |
|---|-----|----|
| Clicking or popping of the jaw? | YES | NO |
| Facial Pain? (joint, ear, side of face) | YES | NO |
| Difficulty opening or closing jaws? | YES | NO |
| Head, neck or shoulder aches? | YES | NO |
| Sore muscles (jaw, neck, shoulder)? | YES | NO |

- Are you satisfied with the appearance of your teeth?** YES NO
- Would you like to keep your teeth all of your life? YES NO
- Do you feel nervous about having dental treatment? YES NO
- If so, what is your greatest concern? _____
- _____
- _____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____

Dental Hygienics

7683 SE 27th #441, Mercer Island, WA 98040
206-948-7355 Fax: 206-420-4999

AUTHORIZATION FOR DENTAL HYGIENE SERVICES

I hereby request and authorize that _____

Print client's name

receive dental hygiene services. The treatment is not a comprehensive oral health care service, but is provided as a preventive service only. The patient should be examined by a licensed dentist for comprehensive oral health care services. The first dental hygiene service appointment will include initial evaluations, routine or difficult prophylaxis, or quadrant periodontal debridement as indicated by the oral conditions, denture/partial cleaning, and fluoride application as needed, unless advance directives are given to Dental Hygienics.

I have read and understand the general information for informed consent for dental hygiene services. I have read, signed and dated the Client Confidentiality form. I accept the risks of treatment in hopes of obtaining the desired beneficial results of treatment. I understand that the results of treatment cannot be guaranteed and that I am free to withdraw my consent at any time.

_____ Please check here for Private Client: I agree that fees for services will be paid, upon receipt of statement, to Dental Hygienics by the responsible party indicated below.

_____ Please check here for Client with Private Dental Insurance: I agree that fees for services will be paid, upon receipt of statement, to Dental Hygienics by the responsible party indicated below.

I have contacted my insurance company to determine:

- if my policy will pay for services directly provided by a dental hygienist
- which services my policy will pay for
- if my insurance company requires prior authorization for these services

I have obtained forms that I can submit to my insurance company for reimbursement. I will send one of these insurance forms to Dental Hygienics to keep on file for provider information that will assist the responsible party with insurance form submitting. This form will be returned by Dental Hygienics with the invoice statement to the responsible party, to then be completed, signed and mailed by the responsible party to the insurance company for reimbursement.

_____ Please check here for Medicaid Client:

I understand that Medicaid covers a very limited number of dental services, and that Dental Hygienics may be providing services beyond those covered by Medicaid. I have been told about these non-Medicaid services and agree to pay privately for those services that Medicaid will not pay for.

Or, if the client has both Medicaid and private dental insurance, private insurance is the primary payer for service per Medicaid regulation. I will assist with private insurance and Medicaid subscriber information to Dental Hygienics so that Dental Hygienics can bill Medicaid for the services that private insurance does not pay for. (Please list all private and Medicaid insurance information on the back of this form.)

Signature of responsible party:

Print Name: _____

Address: _____

Telephone: _____ Date _____

Family Contact/Friend/DPOA for Verification:

Telephone: _____

(Please send a signed copy of this authorization to Dental Hygienics)

Private Dental Insurance Information

Insurance Company Name _____

Insurance Co. Address _____

Insurance Co. Telephone _____

Name of Subscriber _____

ID Number of Subscriber _____

Group Number (if given) _____

Plan Number (if given) _____

Medicaid ID Number (if applicable) _____

(Please enclose a copy of the subscriber's current Medicaid coupon)

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dental Hygienics (DH) is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. DH will not use or disclose your health information except as described in this Notice. This Notice applies to all of the dental and medical records generated by DH, as well as records we receive from other providers.

USES AND DISCLOSURES REQUIRING YOUR CONSENT: With your consent, DH may use and disclose your health information for the following purposes.

TREATMENT: DH may use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your dental or medical record information to your attending dentist and other health care providers who have a legitimate need for such information in your care and treatment. Different departments may share health information about you in order to coordinate specific services, such as prescriptions, lab work and x-rays. We may use or disclose your health information for appointment reminders or other supportive services.

PAYMENT: DH may release health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. The information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill, and may include copies or excerpts of your dental record which are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the procedures and supplies used. We may also provide payment information to other care providers who have been involved in your care, e.g., a dentist of record.

ROUTINE HEALTHCARE OPERATIONS: DH may use and disclose your health information during routine healthcare operations, including quality assurance, utilization review, dental/medical review, internal auditing, accreditation, certification, licensing or credentialing activities of DH, dental/medical research and educational purposes. DH may engage outside companies to carry out certain aspects of routine healthcare operations. These entities are called the "business associates" of DH. DH may need to disclose your health information to the business associates to allow them to perform their duties. The business associates will, in turn, use and disclose your health information as they conduct business on DH's behalf. Examples of business associates, include, but are not limited to consultants, accountants, lawyers, billing agents, medical transcriptionists and third-party billing companies. DH requires the business associate to protect the confidentiality of your health information.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: DH may not disclose your health information to persons outside of DH for purposes other than treatment, payment or healthcare operations without your authorization. In addition, DH may not use or disclose psychotherapy notes written by your mental health provider, if any, without your authorization, even for treatment, payment or healthcare operations. You have the right to revoke any authorization you have previously given by submitting a written statement of revocation to DH.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT:

FAMILY/FRIENDS: DH may disclose your health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your health information in this manner, please tell us.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT CONSENT OR AUTHORIZATION

RESEARCH: Under certain circumstances, DH may use and disclose your health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

REGULATORY AGENCIES: EDHS may disclose your health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment, the Joint Commission on Accreditation of Healthcare Organizations or the Board of Dental Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

LAW ENFORCEMENT/LITIGATION: EDHS may disclose your health information for law enforcement purposes as required by law or in response to a court order.

PUBLIC HEALTH: As required by law, EDHS may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, the EDHS is required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

WORKERS' COMPENSATION: EDHS may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

MILITARY/VETERANS: EDHS may disclose your health information as required by military command authorities, if you are a member of the armed forces.

AS OTHERWISE REQUIRED BY LAW: EDHS will disclose your health information in any situation where such disclosure is required by law (e.g., child abuse, domestic abuse).

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION: Although all records concerning your treatment obtained at EDHS are the property of EDHS, you have the following rights concerning your health information:

RIGHT TO CONFIDENTIAL COMMUNICATIONS: You have the right to receive confidential communications of your health information by alternative means or at alternative locations. For example, you may request that the EDHS only contact you at work or by mail.

RIGHT TO INSPECT AND COPY: You generally have the right to inspect and copy your health information, except as restricted by your provider or by law.

RIGHT TO AMEND: You have the right to request an amendment or correction to your health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your dental record.

RIGHT TO AN ACCOUNTING: You have the right to obtain a statement of the disclosures that have been made of your health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your health information. If we are able to agree to your request, we will abide by the restrictions.

RIGHT TO RECEIVE COPY OF THIS NOTICE: You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.

RIGHT TO REVOKE CONSENT OR AUTHORIZATION: You have the right to revoke your consent or authorization to use or disclose your health information, except to the extent that action has already been taken in reliance on your consent or authorization.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If you have questions or would like more information regarding any of the rights listed above, please contact EDHS.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with the EDHS or with the Secretary of the Department of Health and Human Services. To file a complaint with EDHS, please contact: Anita Rodriguez, RDH, BS at (360) 733-3160. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE: EDHS will abide by the terms of the Notice currently in effect. EDHS reserves the right to change the terms of this Notice at any time. Any new notice provisions will be effective for all protected health information that it maintains. EDHS will mail any revised Notice to the address indicated on the Consent to Treat Agreement, Patient Information Forms or such other address you may provide to us from time to time.

Signature of client or DPOA _____ **Date** _____

Dental Hygienics
Deb Fredrikson
206-948-7355

ESTIMATED FEES FOR SERVICES

Initial one time Hygiene Assessment/periodontal evaluation...	\$35.00
Periodontal charting (1x/yr).....	\$10.00
Prophylaxis (routine cleaning & Fluoride).....	\$75.00
Deep Cleaning (scale and root plane) per hour.....	\$85.00
Perio Maintenance & Fluoride.....	\$80.00
Cancer screen.....	N/C.
Blood Pressure Check.....	N/C
Internal and External Exams.....	N/C
Evaluation of teeth and periodontal tissues.....	N/C
Denture/ Removable Partial cleanings.....	N/C
Desensitizing.....	N/C

Payment day of services
Cash/check