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 the Martha's Vineyard Hospital Dental Center, a Community Health Center, or a private dentist.

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:

Vineyard Smiles: (508) 696-0020 x107
info@mvhealthcareaccess.org, or
www.mvhealthcareaccess.org

114 New York Avenue, Oak Bluffs

Polished: gould.ellen@gmail.com

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

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
2) I understand it is my responsibility to inform the dental provider of any changes in my medical history and insurance information.
3) I understand that my health information may be used for treatment, payment and health care operations.
4) If I have dental insurance, I authorize my insurance carrier to be billed for any services provided by Polished LLC.
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:_____

FREE DENTAL CLEANINGS

SPONSORED BY YOUR TOWN BOARD OF HEALTH

Joining forces to provide dental services to adults in Dukes County.

Services may include:

- ♦ Routine Dental Screenings & Exams
- ♦ Diagnosis
- ♦ Dental Cleanings
- ♦ Fluoride Treatment
- ♦ Oral Hygiene Instruction
- ♦ Referrals

PLEASE SIGN OTHER SIDE!

INCOME LIMITS MAY APPLY

See Reverse

PATIENT INFORMATION

Please be sure to complete all sections.

Please verify that your income is below:

1 person: $30,000 yes _____ no_____
2 people: $40,000 yes _____ no_____
3 people: $51,000 yes _____ no_____
4 people: $61,000 yes _____ no_____

You must answer 'yes' to qualify for services!

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:

DENTAL INSURANCE

Please have a copy of your MassHealth or other Dental Insurance Cards (not Medicare), IF YOU HAVE ONE, so we can bill the insurance company for the dental services.

___ I have no dental insurance .

__ 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

Subscriber's Name

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

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

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

Subscriber's Social Security Number

Subscriber's ID

Group Policy Number

YOUR DOCTOR'S INFORMATION

Physician's Name

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

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
☐	☐	STD	☐	☐	Stomach/GI Disorder
☐	☐	Other: _____			