Select dental services are now being offered along with regularly scheduled medical visits (checkups) at HealthEast Roselawn Clinic! A collaborative practice dental hygienist will provide a dental screening, and/or teledental services for pregnant mothers, infants, and children to age 18. Services may include dental screening, x-rays, intraoral pictures, teledental exams, tooth/mouth care instructions, nutritional guidance, fluoride varnish and/or silver diamine fluoride application to strengthen teeth or slow cavities. Please complete and sign this form if you, or your child, would like to participate in this program.

You/your child should receive a dental exam at least once a year. Dental screening does not take the place of a dental examination.

**INSURANCE INFORMATION:** Please check one of the boxes below. Payment from Minnesota Health Care Programs and other insurance plans helps to cover the cost of this program.

- I am/My child is covered by Minnesota Health Care Programs. Circle the name of the insurance plan and fill in the ID numbers.
- I am/My child is covered by another dental insurance plan not listed above:

**CONSENT TO TREATMENT**

I give Community Dental Care’s Physician-Based Program permission to:

- provide a dental screening, teledental and/or preventive services for me/my child. (Services may include a dental screening or tele-dental exams, x-rays, intraoral images, tooth brush cleaning, mouth care instructions, nutritional guidance, application of fluoride varnish and/or silver diamine fluoride.)
- collect payment from Medical Assistance or private insurance
- allow the dentist to access my, or my child’s, medical history and records and share dental exam records with physician/medical provider
- use dental records for treatment and billing purposes
- contact me to provide health care information about treatment, payment, my insurance, or my account.

By signing this form, I consent for me/my child to participate in the Community Dental Care Physician-Based Program. I have received a copy of Community Dental Care’s Notice of Private Practices, and I am aware that a copy of the Notice of Privacy Practices is also available for me to view on the Community Dental Care website (cdentc.org). Consent is valid for 24 months to provide follow-up services.

**INSURANCE INFORMATION:**

Please check one of the boxes below. Payment from Minnesota Health Care Programs and other insurance plans helps to cover the cost of this program.

- I am/My child is covered by Minnesota Health Care Programs. Circle the name of the insurance plan and fill in the ID numbers.
- I am/My child is covered by another dental insurance plan not listed above:

**CONSENT TO TREATMENT**

I give Community Dental Care’s Physician-Based Program permission to:

- provide a dental screening, teledental and/or preventive services for me/my child. (Services may include a dental screening or tele-dental exams, x-rays, intraoral images, tooth brush cleaning, mouth care instructions, nutritional guidance, application of fluoride varnish and/or silver diamine fluoride.)
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**INSURANCE INFORMATION:**

Please check one of the boxes below. Payment from Minnesota Health Care Programs and other insurance plans helps to cover the cost of this program.

- I am/My child is covered by Minnesota Health Care Programs. Circle the name of the insurance plan and fill in the ID numbers.
- I am/My child is covered by another dental insurance plan not listed above:
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