Sound Dental Care
Enrollment Form

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Sound **D**ental **C**are
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Please return this form to our mailing address, fax number, or to the resident's facility.

Section A: Resident Information

Full Name: ______________________ Date of Birth: ______________________

Address: ____

Section B: Guarantor (Party responsible for health care authorizations and payment for care)

Full Name: ______________________ Relationship to Resident: ______________________

Address: ____

Email: ______________________ Phone Number: ______________________

Section C: Insurance and Other Payment (Please annotate one of the following)

Private Payment: ____________ Medicaid: ____________ Other: ______________________

Section D: Acknowledgements, Affirmations, and Authorizations

1. I acknowledge that I have received a copy of Sound Dental Care's Notice of Health Information Privacy Practices (HIPPA) or reviewed said notice at www.sounddentalcare.com/patient-information/hippa-notice.

2. I acknowledge and understand that I can discontinue service at any time and will not be charged for cancellations or appointments should a resident refuse treatment.

3. I affirm that I am authorized to coordinate the care for the resident identified in Section A. Furthermore, I affirm that I am responsible for payment on dental services rendered. Residents that qualify for Medicaid will only be charged for services authorized by Medicaid. The guarantor identified in Section B is **not** financially liable for services that Medicaid fails to cover.

4. I authorize Sound Dental Care to obtain medical records from the resident's care facility for the purpose of providing dental care. Sound Dental Care is authorized to request, record, and archive the resident's diagnoses, current medications, historical medications, and history of healthcare providers.

5. I authorize Sound Dental Care to obtain authorization for dental services from the resident's physician of record or from the facility's medical staff.

6. I authorize Sound Dental Care to contact me about the resident's oral care, the guarantor's billing preferences, and any issues surrounding insurance coverage.

Printed Name: ______________________________ Date: ______________________

Signature: ____

INFORMED CONSENT - APPLICATION OF SILVER DIAMINE FLUORIDE

Silver Diamine Fluoride (SDF) is an antibiotic liquid medication. It is used to slow or stop decay AND treat tooth sensitivity.

Sound Dental Care would like your consent to perform the following procedure:

1) Dry the teeth
2) Place a small amount of SDF on visible cavities
3) Allow to dry (optimally one minute)
4) Apply fluoride varnish to cover

Benefits:

- SDF may slow or stop tooth decay
- SDF may help relieve sensitivity

Possible Side Effects:

- The cavity and white pre-cavities will darken permanently as the decay process stops.
- Healthy tooth structure will not discolor.
- Discolored tooth structure can be covered or replaced with a filling at a later date.
- Tooth colored fillings and crowns may also discolor if SDF is applied to them. Normally this is temporary and can be polished off.
- If SDF comes in contact with skin and/or gums, temporary discoloration may occur. It will disappear in 1-3 weeks.
- Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay, and no guarantee of success is granted or implied.
- This treatment to stop or slow decay may not prevent the cavity from growing. In that case the tooth will require further treatment, such as repeat SDF, filling or crown, root canal or extraction.

Alternatives to SDF:

- No treatment, which may lead to continued deterioration of the tooth structure and cosmetic appearance. Symptoms may increase in severity.
- Other treatment may include placement of fillings, other restorations, or extraction.

Patient Name ______________________________ Date __________________

Signature of Patient or Guardian

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