



SENIOR
smile

Namita K. Thapar-Dua, DDS
Providing Mobile Dental Care
Serving Maryland, DC & Virginia
301.875.7477

CONSENT FOR TESTING

FOR: _____ (Name of Patient)

IF APPLICABLE, then POA/Guardian Name: _____ Relationship: _____

In order to comply with Occupational Safety & Health Administration Blood borne Pathogen Regulation (OSHA) we are requesting you consent to submit to testing of your blood for blood borne pathogens, hepatitis B, hepatitis C or HIV if an exposure occurs (needle stick injury and/or blood splatter) to one of the staff. Testing will be done at no cost to you. All information regarding an exposure is confidential.

Print Name of Patient/POA/Guardian: _____

Signature of Patient/POA/Guardian: _____ Date: _____

Privacy Statement

In order to comply with the new privacy rules governing the sharing of medical information for billing purpose, we need your permission. PLEASE CHECK the appropriate box for additional permissions:

- May leave message on my voicemail/answering machine at: _____
- May send an email to: _____
- May fax information to: _____
- May share information with the following members of my family:
 - _____ Phone Number: _____
 - _____ Phone Number: _____
 - _____ Phone Number: _____

Print Name of Patient/POA/Guardian: _____

Signature Patient/POA/Guardian: _____ Date: _____