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

SENIOR SMILE Consent Form (Part 1)

Billing Information for Responsible Party (Power of Attorney and/or Guardian)

Full Name: _____ **Relation to Patient:** _____
First *Last*

Address: _____

_____
City *State* *Zip*

Phone (Home): _____ **Phone(Cell):** _____

Email: _____

Patient Information

Full Name: _____
First *Last*

Facility: _____

Date of Birth: _____

	NO	YES	
Does Patient have a Heart Murmur?	☐	☐	
Does Patient have a Pacemaker?	☐	☐	
Does Patient have any Allergies?	☐	☐	If yes, list them: _____
Does Patient take any Blood Thinners?	☐	☐	If yes, list them: _____
Does Patient have any Joint Replacements (hip, shoulder or knee/single or both)?	☐	☐	If yes, what joint(s) and when: _____

I hereby authorize SENIOR SMILE to administer treatment to provide any anesthetics and dental procedures as may be necessary or advisable in the diagnosis & treatment of the patient's dental condition. Furthermore, I am giving consent to release privileged information such as the medical history, so the doctor can properly perform treatment.

Signature: _____ Date: _____
Patient and/or Power of Attorney/Guardian