AltaMed
QUALITY CARE WITHOUT EXCEPTION™

TELEDENTISTRY Consent to Perform Dental Treatment

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Relationship to Patient: _____

The following dental procedures may be performed for participants in the Teledentistry program:[1]

1. **Exam:** The exam procedure includes a comprehensive exam, x-rays, consultation, discussion of findings, and treatment planning.

2. **Cleaning of teeth:** A teeth cleaning removes stains on teeth caused by food or certain bacteria and deposits (calculus or tartar). Clean teeth and mouth allow the dental professional to examine the tiny grooves, pits and fissures on teeth which can allow plaque and bacteria to hide. This procedure is usually painless and helps introduce the patient to dental care.

3. **Dental Sealants:** Sealants are a protective coating that helps with the prevention of tooth decay by shielding the chewing surfaces of the patient's teeth. Because the sealant is only placed on the biting surface of the tooth, areas on the side and between teeth are still at risk for decay.

4. **Application of Fluoride:** Fluoride is a gel applied to the teeth that works as an effective cavity prevention procedure. It strengthens the teeth and makes them more resistant to decay.

5. **Remineralization:** Remineralization is the use of fluoride, antimicrobials, and xylitol to harden a tooth's surface in cases where the tooth has a cavity starting and a filling is not yet necessary.

6. **Deep Cleaning (SRPs**): A deep cleaning treatment removes buildup (tartar) from the root and clinical crown of the teeth. Instruments such as scalers and ultrasonic tips are used with irrigation and requires anesthetic.

TELEHEALTH DISCLOSURE:

I understand this is a telehealth program, which includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio (such as telephone), audio-video (such as Skype), or data communications (including email or texting). I understand that telehealth also involves the communication of a patient's medical information, both orally and visually, to health care practitioners located in California. I understand that the laws that protect the confidentiality of a patient's medical information also apply to telehealth.

I understand there are risks from telehealth, including, but not limited to, the possibility, despite reasonable efforts on behalf of AltaMed, that: the transmission of medical information could be disrupted or distorted by technical failures or interrupted by unauthorized persons; or the electronic storage of medical information could be accessed by unauthorized persons.

_____ (Patient/Parent/Guardian Initials)

[1]The treatment plan may change due to conditions identified while working on the teeth.

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CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION:

I hereby authorize the release and exchange of information collected at the visit to dental professionals affiliated with AltaMed's Teledentistry program and other health or government agencies where I may be referred for dental treatment.

This authorization shall remain effective until revoked in writing and delivered to AltaMed at 2040 Camfield Ave., Los Angeles, CA 90040.

_____ (Patient/Parent/Guardian Initials)

TREATMENT AUTHORIZATION:

I have read and understand the information provided above. I have discussed any questions with AltaMed, and all of my questions have been answered to my satisfaction.

I hereby authorize AltaMed's Teledentistry program and/or designated staff to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate by the dental professional to complete an examination in order to make a thorough diagnosis. Upon such diagnosis, I authorize AltaMed's Teledentistry program to perform such cleanings, fluoride applications, sealants or Deep cleaning (SRPs)as needed and recommended for my care, or the patient's in my absence.

This authorization shall remain effective until revoked in writing and delivered to AltaMed at 2040 Camfield Ave., Los Angeles, CA 90040.

Patient/Parent/Guardian Signature: _____ Date: _____

Dental Professional's Signature: _____ Date: _____