Teledentistry Consent and Notice

A licensed dental professional who provides services via telehealth is subject to the requirements and definitions set forth in Business & Professions, to the Dental Practice Act and to the regulations adopted by the Dental Board.
“Telehealth” is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth includes synchronous interactions and asynchronous store-and-forward transfers. “Asynchronous store and forward” means the transmission of a patient’s information from an originating site to the health care provider at a distant site without the presence of the patient.

Prior to the delivery of health care via telehealth, a health care provider at the originating site must verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. The verbal consent shall be documented in the patient’s record. The failure of a health care provider to comply with this section shall constitute unprofessional conduct.

The Dental Board further requires that if a registered dental assistant in extended functions, a registered dental hygienist or a registered dental hygienist in alternative practice treats a patient pursuant to the diagnosis and treatment plan authorized by a supervising dentist at a location other than the dentist’s practice location, the dentist must provide to the patient or patient’s representative written notification that the care was provided at the direction of the authorizing dentist. The notification must include the authorizing dentist’s name, practice location address and telephone number. The provision requiring patient notification of the authorizing dentist is not required for dental hygiene preventive services provided in public health programs as specified and authorized in for dental hygiene care when provided as specified and authorized.

In telehealth connected dental teams, dental assistants in extended functions, registered dental hygienists and registered dental hygienists in alternative practice are permitted specified duties upon completion of approved training.

Instruction for the Dental Practice

Following is a form that serves both as a notice that complies with the Dental Board’s requirement and to obtain informed consent for Teledentistry. Complete the top half of the first page prior to having the patient or patient’s parent or legal guardian sign it. Provide a copy to the patient.

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BEVERLY HILLS

Consent to Participate in a Teledentistry System

Name:_____ Patient ID _____

Purpose: The purpose of this form is to get your permission for you to participate in a system of dental care called "Teledentistry." You will be offered an exam and limited dental treatment in a community location that may not be a dental office or clinic.

The dental care providers in this system include:
Dental Professional - Name: _____

Dental Professional License Category:

- ☐ Registered Dental Assistant (RDA)
- ☐ Registered Dental Hygienist working in a Public Health Program (RDH)
- ☐ Registered Dental Hygienist in Alternative Practice (RDHAP)

Dental care is provided at the direction of the following dentist:
Dentist – Name: _____
Dentist – Address: _____
Dentist – Telephone: _____

The Teledentistry system allows a dentist to view your records through the internet. The dentist will then make recommendations about your treatment. The dentist may not see you in person.

1. **What is a Teledentistry consultation?** Teledentistry is a way to provide care for people who do not or cannot go to a dentist's office. Teledentistry uses electronic dental records such as electronic versions of X-rays, photographs, recordings of the condition of your teeth, health and other history information. These records are reviewed at a later time. These records or other electronic communications are known as "store and forward" records. The goal of the Teledentistry system is to have the dentist create recommendations for you for dental care.
2. **What happens during Teledentistry consultation?** The RDA, RDH or RDHAP will examine your mouth and collect electronic dental records. That person will record what she/he sees. Your medical and dental history and personal health information may be discussed with other health professionals. These discussions will occur through phone calls or "store and forward" technology. A Teledentistry consultation may require more than one visit.
3. **What are the risks, benefits and alternatives?** The benefits of Teledentistry include having access to a dentist and additional dental information without having to travel to a dental office or clinic. Some of the procedures that you may receive include X-rays, cleaning, fluoride treatments, sealants or temporary fillings. A potential risk of Teledentistry is that a face-to-face consultation with a dentist may still be necessary after the Teledentistry appointment. This could be because of your specific medical or dental condition or for other reasons. Recommendations will be made to you about your future dental care after the Teledentistry consultation. These could include recommendations about whether or not to see a dentist in a dental office or dental clinic. A visit to a dental office may be needed in the future even if it is not recommended now. The recommendations may change if more information about your dental needs becomes known. The alternative to Teledentistry consultation is a face-to-face visit with a dentist. The practice of dentistry is not an exact science. Therefore, any specific results cannot be guaranteed.

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4. **Confidentiality:** Current federal and California laws about confidentiality apply to the information used or disclosed during your Teledentistry consultation. You will be provided with a separate document, which describes how your private information will be handled. This is known as the "Notice of Privacy Practices."

5. **Rights:** You may choose not to participate in a Teledentistry consultation at any time before and/or during the consultation. If you decide not to participate, it will not affect your right to future care or treatment. You have the option to seek dental consultation or treatment in a dental office at any time before or after the Teledentistry consultation. If an injury occurs as a result of procedures provided by the RDA, RDH or RDHAP, notify that person and the dentist. They will make arrangements for appropriate treatment of the injury.

My dental care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I agree to have records, including electronic versions of X-rays, photographs, charting of conditions and health and other history information, collected from me and shared and used in this study as described in this consent form and in the "Notice of Privacy Practices" I have received. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment I have requested and authorized.

_____ or _____

Signature of Patient or Signature of Patient's Parent/ Legal Guardian

_____ or _____

Name of Patient (print) or Name of Patient's Parent/ Legal Guardian (print)

_____ _____

Name of Interpreter/ID# (print) Signature of Interpreter

_____ _____

Signature of Witness (required if patient unable to sign) Relationship of Witness to Patient

_____

Name of Witness (print)

_____

Date of Signing

Refusal: I refuse to participate in a Teledentistry consultation as described above.

_____

Signature:

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Patient Information (CONFIDENTIAL)

Date:_____

Name:_____ Date of Birth:_____ Patient #:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ SS#/SIN:_____

Cell Phone:_____ Home Phone:_____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Whom may we thank for referring you? _____

Person to contact in case of Emergency _____

Responsible Party

Name of Person Responsible for this Account:_____ Date of Birth:_____

Relationship to Patient:_____ Is this person currently a patient in our office? ☐Yes ☐No

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Driver's License: _____

Cell Phone:_____ Home Phone:_____

Employer:_____ Work Phone:_____ SS#/SIN:_____

Insurance Information

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is collected in full at each appointment

☐ Cash Credit Card: ☐VISA ☐MasterCard ☐American Express ☐Personal Check Name of

Insured:_____ Date of Birth:_____

Relationship to Patient:_____ SS#/SIN:_____ Date Employed:_____

Name of Employer:_____

Address of Employer:_____ City:_____ State:_____ Zip:_____

Insurance Company: _____

Insurance Company Address:_____ City:_____ State:_____ Zip:_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐No ☐Yes IF YES, COMPLETE THE FOLLOWING

Name of Insured:_____ Date of Birth:_____

Relationship to Patient:_____ SS#/SIN:_____ Date Employed:_____

Name of Employer:_____

Address of Employer:_____ City:_____ State:_____ Zip:_____

Insurance Company: _____

Insurance Company Address:_____ City:_____ State:_____ Zip:_____

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Patient Medical History

Physician: _____ Office Phone:_____ Date of Last Exam:_____

	YES	NO
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
Are you taking any medication(s) including Non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
Have you ever taken Fen-Phen/Redux?		
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
Do you use tobacco?		
Do you use controlled substances?	☐	☐
Are you wearing contact lenses?	☐	☐
	☐	☐
13. *Do you have or have you had any of the following?*	☐	☐

	YES	NO
Are you allergic to or have you had any reactions to the following?	☐	☐
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)_____		
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

AIDS or HIV Infection ☐	Diabetes ☐	High Blood Pressure ☐	Radiation Therapy ☐
ADHD ☐	Down Syndrome ☐	Hepatitis A ☐	Recent Weight Loss ☐
Allergies ☐	Easily Winded ☐	Hepatitis B ☐	Rheumatic Fever ☐
Anemia ☐	Emphysema ☐	Hepatitis C ☐	Stroke ☐
Arthritis ☐	Epilepsy / Convulsions ☐	Implant (s) ☐	Swollen Ankles ☐
Asthma ☐	Fainting Spells ☐	Jaundice ☐	Sexually Transmitted Disease ☐
Angina ☐	Frequently Tired ☐	Joint Replacement ☐	Stomach Troubles ☐
Autism ☐	Glaucoma ☐	Kidney Disease ☐	Seizures ☐
Blood Transfusion ☐	Hay Fever ☐	Leukemia ☐	Tuberculosis ☐
Cardiac Pacemaker ☐	Heart Attack ☐	Low Blood Pressure ☐	Tumors ☐
Cancer ☐	Heart Disease ☐	Liver Disease ☐	Thyroid Problems ☐
Cerebral Palsy ☐	Hearth Murmur ☐	Mitral Valve Prolapse ☐	Ulcers ☐
Chest Pain ☐	Heart Trouble ☐		

If medical condition is not listed, please specify:_____
_____
_____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth Sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?	☐	☐
Clicking	☐	
Pain (joint, ear, side of face)	☐	
Difficulty in opening or closing	☐	
Difficulty in chewing	☐	

	YES	NO
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X
Signature of Patient (or Parent/Guardian if minor)Date