NEW LOOK DENTAL

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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 in Extended Functions (RDAEF)
❒ 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 RDAEF, 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 tele-dentistry 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.

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 RDAEF, 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.

_____		_____
Signature of Patient	**or**	**Signature of Patient's Parent/Legal Guardian**
_____		_____
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: _____