

MISSION OF MERCY CONSENT FOR CARE

Patient’s Name: _____ Date of Birth: _____ ID#: _____

I hereby authorize the Dentists, Hygienists, Dental Assistants and/or other health care providers of the Virginia Dental Association Foundation’s (VDAF) Mission of Mercy (MOM) project, some of whom might be closely supervised advanced students, to examine and/or treat me and/or my dependent as named above. I understand that it is my responsibility to notify MOM of any changes in contact information, such as change of address or new telephone number when follow-up may be necessary.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING—As a health care provider, we are making available to you the following notice:

1. If one of our health care professionals, workers or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the “AIDS” virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. By checking “YES” below, you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluids of one of our health care professionals, workers or employees in a way that may transmit the disease, the person’s blood will be tested for infection with human immunodeficiency virus (the “AIDS” virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the results of the test.

The deemed notice for HIV, Hepatitis B and C exposure has been explained to me and I understand it. Yes No

IMPORTANT NOTICE

Virginia Dental Association Mission of Mercy (MOM) Project is a 501c(3) dental outreach program and is NOT part of a government program. Mission of Mercy volunteers may not be able to provide you with all the services you need, but if you would like to consult with our volunteer team and receive the type of treatment being offered today, PLEASE READ THE PATIENT WAIVER BELOW VERY CAREFULLY AND THEN SIGN THE WAIVER FORM.

DENTAL PATIENT NOTE: While the volunteer hygienists, dentists and oral surgeons offer high quality procedures with good equipment, I understand that because of the number of people needing to be seen, I might not receive multiple extractions or multiple fillings. I understand that I might have certain medical conditions which would keep me from having the type of treatment I am requesting. I also understand that the dental care providers are volunteers, some from out-of-town, and are not available for follow-up care in the event of complications. I agree to seek any follow-up care I might need from my local dentist, health department, family physician or a hospital emergency room.

In consideration of the free health care services received on the date below, I, for myself and anyone entitled to claim through me, do hereby waive and release the Virginia Dental Association, Virginia Dental Association Foundation (VDAF), Mission of Mercy (MOM), and any persons or organizations acting on their behalf or sponsoring or volunteering at this clinic, from all claims of liability arising out of my acceptance of such free care including, but not limited to medical, surgical, dental or other health care or medical advice.

I grant to the VDAF Mission of Mercy and its agents the right to use my picture, voice and other reproductions of my physical likeness in connection with advertising or publicizing VDAF Mission of Mercy and its activities in all form of media in perpetuity.

I the undersigned patient consent to the release of my patient records to other licensed health care professionals as necessary. I have read, or had read to me, and understand and agree to all of the above.

Patient Signature (Parent or Guardian if patient is under 18 years of age)

Date