Kimberly Farrell, RDHAP
Mobile Dental Hygiene Services
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PATIENT NAME ____ **Date of Birth** ________________________
PATIENT ADDRESS ____

DENTAL HISTORY

DENTIST'S NAME __________________________ **Address**____
Phone (_____)______________________________ **Fax (____)**____

MEDICAL HISTORY

PHYSICIAN'S NAME ________________________ **Address**____
Phone (_____)______________________________ **Fax (____)**____

Has antibiotic Pre-med been needed for dental treatment in past? yes no unknown

Date of last dental care ______________
Please describe any dental concerns: ____
Please describe medical condition or current or long-term disability if any: ____

Check (✓) if you have any of the following:

☐ Anemia	☐ Rheumatic Fever	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Circulatory Problems
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Parkinson's	☐ Cerebral Palsy	☐ Special Needs	☐ Dementia
☐ Multiple Sclerosis	☐ Alzheimer's	☐ Blind	☐ Disabled

MEDICATIONS

List medications you are currently taking:
____
____

ALLERGIES

☐ **Latex**
☐ **Others**______________________________

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to maintain the confidentiality of your health information. This describes how we may use and disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that we are permitted or required by law. We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health/dental information may be provided to a dentist to whom you have been referred. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your care. We may use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

NOTIFICATION TO CONSUMERS DENTAL HYGIENIESTS ARE LICENSED & REGULATED BY THE DENTAL HYGIENE COMMITTEE OF CALIFONIA (916)263-1978 www.DHCCA.CA.GOV

Name of **RESPONSIBLE PARTY**: ______________________ Relationship to Patient: __________________________________
Phone: _________________________Fax:__________________________Email:__________________________________
Mailing/Billing Address: ___________________________________City,State,Zip:___________________________________
Permission Granted for Review of Medical Records / Permission Granted to take picture of patient for chart ID and educational purposes

***All fees are ultimately the responsibility of the* "RESPONSIBLE PARTY" unless patient has Denti-Cal**
SIGNATURE OF RESPONSIBLE PARTY: ____________________________________ **Date _____/_____/_____**

The above information is accurate and complete to the best of my knowledge. I will not hold Kimberly Farrell, RDHAP, Smiles On The Run or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.
SIGNATURE: ____ **Date _____/_____/_____**