DENTAL HYGIENE FOR THE HOMEBOUND

Brenda Kibbler, RDHAP, BHSc (818) 521-8572

Registered Dental Hygienist in Alternative Practice www.hygienehousecalls.com

PATIENT INFORMATION

City, State, Zip	Please Print Dr.	☐ Mr.		⁄Irs.□ I	Ms.□					
Home Address	Patient Name					Date of Birth				
City, State, Zip	Home Address					Home Phone				
Name of Special Care Facility Facility Address City, States, Zip	City, State, Zip									
Practity Address	Name of Special (Care Fa	cility							
City, States, Zip	Facility Address_									
Facility Contact Name	City, States, Zip					Phone				
Name of Physician Phone Physician's Address City, State, Zip Name of Dentist Phone Physician's Address City, State, Zip Phone Physician's Address City, State, Zip Last dental examination Last dental cleaning Last dental cleaning To whom can I thank for referring you PMEDICAL HISTORY Certain illnesses and drugs may indicate an alteration to your treatment. In my endeavor to render the best possible services to you, it is necessary to have the knowledge of the following: Are you taking any of the following drugs or medications? Yes No Yes										
Physician's Address						Phone				
Dentist's Address	Physician's Addre	ess					City, Stat	te, Zip		
Dentist's Address										
MEDICAL HISTORY Certain illnesses and drugs may indicate an alteration to your treatment. In my endeavor to render the best possible services to you, it is necessary to have the knowledge of the following: Are you taking any of the following drugs or medications? Yes No Yes No Yes No Yes No Are you alteriate or have you experienced an unusual reaction to any of the following? Yes No Yes No Yes No Are you allergic or have you experienced an unusual reaction to any of the following? Yes No Yes No Yes No Are you altergic or have you experienced an unusual reaction to any of the following? Yes No Yes No Are you altergic or have you experienced an unusual reaction to any of the following? Yes No Yes No Are you altergic or have you experienced an unusual reaction to any of the following? Yes No Yes No Are you altergic or have you experienced an unusual reaction to any of the following? Yes No Yes No Yes No Are you altergic or have you experienced an unusual reaction to any of the following? Yes No Yes No Are you altergic or have you experienced an unusual reaction to any of the following? Yes No Yes No Yes No Are you have any of the following? Yes No Yes No Yes No Yes No Yes No Pheumatic fever hepatitis or jaundice epilepsy or convulsions prheumatic fever hepatitis or jaundice epilepsy or convulsions pheating of the following pheatitis or jaundice arthritis pheating of the following pheating of the following										
MEDICAL HISTORY Certain illnesses and drugs may indicate an alteration to your treatment. In my endeavor to render the best possible services to you, it is necessary to have the knowledge of the following: Are you taking any of the following drugs or medications? Yes No Tyes No Theumatic fever Theumatic						Last	t dental clea	aning		
Certain illnesses and drugs may indicate an alteration to your treatment. In my endeavor to render the best possible services to you, it is necessary to have the knowledge of the following: Are you taking any of the following drugs or medications? Yes No Are you taking any of the following drugs or medications? Yes No Antibiotics tranquilizers/anti-depressants blood pressure medicine insulin cortisone (steroids) heart medicine hormones organic / diet supplements anticoagulants Are you allergic or have you experienced an unusual reaction to any of the following? Yes No The John John John John John John John John	To whom can I th	ank for	refer	ring you	<u> </u>					
Certain illnesses and drugs may indicate an alteration to your treatment. In my endeavor to render the best possible services to you, it is necessary to have the knowledge of the following: Are you taking any of the following drugs or medications? Yes No Are you taking any of the following drugs or medications? Yes No Antibiotics tranquilizers/anti-depressants blood pressure medicine										
services to you, it is necessary to have the knowledge of the following: Are you taking any of the following drugs or medications?					MEDICAL H	IIS'	ГORY			
Are you taking any of the following drugs or medications? Yes No antibiotics	Certain illnesses a	and dru	gs ma	y indica	te an alteration to you	r tre	eatment. In	my endeavor to render the best	possible	
Yes No antibiotics	services to you, it	is nece	ssary	to have	the knowledge of the	foll	owing:			
antibiotics	Are you taking an	ıy of thε	follo	wing dr	ugs or medications?					
insulin							5 1 10			
hormones				1	-			<u>*</u>		
Are you allergic or have you experienced an unusual reaction to any of the following? Yes No Quental anesthetic Quental ane					,					
Yes No dental anesthetic				_				_		
dental anesthetic	Are you allergic o				ced an unusual reactio			following?		
codeine				0						
aspirin		_				_	=			
erythromycin					•	=				
Do you have any of the following? Yes No Theumatic fever Theumatic heart disease □ □ hepatitis or jaundice □ □ epilepsy or convulsions Theumatic heart disease □ □ liver disorder Theimatic heart disease □ □ blood transfusion Theart murmur/MVP □ □ kidney disorder Theart attack Theart pacemaker Theart pacemaker The persistent cough Themophilia The persistent cough The persistent cough The persistent cough The persistent cough The positive The po	•				•			other		
Yes No rheumatic fever	•				other antibiotics	Ш				
rheumatic fever	Do you have any					T 7 -	NI.		X 7 N I -	
rheumatic heart disease	rhoumatic fover			0	hanatitis or joundies			anilancy or convulsions		
high blood pressure								- · ·		
heart murmur/MVP										
heart attack	-					_				
heart pacemaker		_			•	_				
hemophilia □ tuberculosis □ cerebral palsy □ HIV positive □ cancer or tumor □ multiple sclerosis □ diabetes □ radiation therapy □ sight impaired □ hearing impaired □ GERD/reflux □ parkinson's disease □		_			~ .	_		± •		
HIV positive	-	_				_				
diabetes	-	_				_		- ·		
hearing impaired	<u>-</u>					=		-		
						_		- -		
hip/joint replacement \square \square osteoporosis \square \square systemic pulmonary shunt \square \square	hip/joint replacement				osteoporosis			systemic pulmonary shunt		
Do you have any disease, condition, or problem not listed?	1 0			dition o	-	_	_	systemic pumonary small		

INSURANCE & FINANCIAL ARRANGEMENTS

To avoid any misunderstandings, all professional fees are charged directly to the patient and it is the responsibility of the patient for payment of dental hygiene fees. Services are not rendered on the basis that insurance companies will pay for treatment. As a courtesy, insurance forms will be completed and filed relative to dental services.

Dental Insurance Company Name	
Claims Address	Group #
Social Security #	Date of Birth
All fees are due in 30 days from date other financial arrangements are mad	of invoice. After 30 days a \$20 per month late fee will be assessed, unless e in advance.
Name of Responsible Party	
	Relationship to patient
City, State, Zip	
medical records and dental hygiene to	or having power of attorney of the named patient, consent to review of reatment as necessary or desirable to the care of the patient. Date
	Date
	Date
	Date
Additional	

Notification to Consumers

Dental Hygienists are licensed and regulated by the Dental Hygiene Committee of California (916) 263-1978 www.dhcc.ca.gov