DENTAL HYGIENE FOR THE HOMEBOUND

Brenda Kibbler, RDHAP, BHSc **Registered Dental Hygienist in Alternative Practice**
(818) 521-8572 **www.hygienehousecalls.com**

PATIENT INFORMATION

Please Print Dr. ❑ Mr.❑ Mrs.❑ Ms.❑
Patient Name_____Date of Birth_____
Home Address_____Home Phone_____
City, State, Zip_____SS#_____
Name of Special Care Facility_____
Facility Address_____
City, States, Zip_____Phone_____
Facility Contact Name_____Title_____
Name of Physician_____Phone_____
Physician's Address_____City, State, Zip_____
Name of Dentist_____Phone_____
Dentist's Address_____City, State, Zip_____
Last dental examination_____Last dental cleaning_____
To whom can I thank for referring you_____

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
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		Yes	No		Yes	No
dental anesthetic	❑	❑	penicillin	❑	❑	barbiturates or sedatives	❑	❑
codeine	❑	❑	sulfa drugs	❑	❑	latex	❑	❑
aspirin	❑	❑	tetracycline	❑	❑	other_____	❑	❑
erythromycin	❑	❑	other antibiotics	❑	❑			

Do you have any of the following?

	Yes	No		Yes	No		Yes	No
rheumatic fever	❑	❑	hepatitis or jaundice	❑	❑	epilepsy or convulsions	❑	❑
rheumatic heart disease	❑	❑	liver disorder	❑	❑	stroke	❑	❑
high blood pressure	❑	❑	blood transfusion	❑	❑	ulcer	❑	❑
heart murmur/MVP	❑	❑	kidney disorder	❑	❑	arthritis	❑	❑
heart attack	❑	❑	lung problems	❑	❑	psychiatric treatment	❑	❑
heart pacemaker	❑	❑	persistent cough	❑	❑	alzheimer's disease/dementia	❑	❑
hemophilia	❑	❑	tuberculosis	❑	❑	cerebral palsy	❑	❑
HIV positive	❑	❑	cancer or tumor	❑	❑	multiple sclerosis	❑	❑
diabetes	❑	❑	radiation therapy	❑	❑	sight impaired	❑	❑
hearing impaired	❑	❑	GERD/reflux	❑	❑	parkinson's disease	❑	❑
hip/joint replacement	❑	❑	osteoporosis	❑	❑	systemic pulmonary shunt	❑	❑

*Do you have any disease, condition, or problem not listed?*_____

PLEASE COMPLETE REVERSE SIDE

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 #_____
Subscriber's Name_____
Social Security #_____Date of Birth_____

All fees are due in 30 days from date of invoice. After 30 days a $20 per month late fee will be assessed, unless other financial arrangements are made in advance.

Name of Responsible Party_____
Phone #_____Relationship to patient_____
Mailing/Billing Address_____
City, State, Zip_____

CONSENT FOR TREATMENT

I, the undersigned, being the patient, or having power of attorney of the named patient, consent to review of medical records and dental hygiene treatment as necessary or desirable to the care of the patient.

Signed_____Date_____
Review_____ Date_____
Review_____ Date_____
Review_____ Date_____

Additional
Comments:_____
_____
_____
_____
_____

Notification to Consumers

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