PURE SMILES MOBILE DENTAL HYGIENE
Practice of Jayme Daley, RDH, RDHAP#544
6680 Alhambra Ave. Suite#159
Martinez, CA. 94553
925-233-6888 Fax 925-335-9462
PureSmilesDH@gmail.com
www.PureSmilesDentalHygiene.com

PATIENT NAME ______________________________ **Date of Birth**______________
Address/Facility Address____
Facility Name ____
Facility Contact ______________________ **Phone**__________ **Email**____________
Responsible Party__________________________ **Relationship**______________
Phone________________________ **Email**___________________________________
Address of responsible party____

DENTAL HISTORY

Antibiotic Pre-med need for dental treatment in past? **yes** **no** **unknown**

Reason for today's visit: ____________________
Name of Dentist____________________ City ____________________ Phone ____________________
Date of last dental cleaning ____________ Check (✓) if you have problems with any of the following:

- ☐ **Bad breath or taste**
- ☐ **Your partial or dentures**
- ☐ **Sensitivity to hot**
- ☐ **Bleeding gums**
- ☐ **Loose teeth or broken fillings**
- ☐ **Sensitivity to sweets**
- ☐ **Sores or growths in your mouth**
- ☐ **Dry Mouth**
- ☐ **Sensitivity when biting**
- ☐ **Food collection between teeth**
- ☐ **Sensitivity to cold**
- **Other**____________

MEDICAL HISTORY

PHYSICIAN'S NAME ______________________ **Address**_______________________________
Phone (____)______________ **Fax (___)**______________
Please describe medical condition or current or long-term disability if any
____

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

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

MEDICATIONS

List medications you are currently taking:
____
____
____
____

Pharmacy Name: ____________________
Phone #: ________________________

ALLERGIES

- ☐ **Aspirin**
- ☐ **Penicillin**
- ☐ **Barbituates (sleeping pills)**
- ☐ **Sulfa**
- ☐ **Codeine**
- ☐ **Latex**
- ☐ **Local Anesthetic**
- ☐ **Others**__________

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold Pure Smiles or any member of the staff responsible for any errors or omissions that I have made in the completion of this form. All fees are the ultimate responsibility of the "RESPONSIBLE PARTY". ALL FEES ARE DUE AT TIME OF SERVICE.

Name RESPONSIBLE PARTY ______________________________ **Relationship to Patient**________________

SIGNATURE:____ **Date** ___/___/____

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CONSENT FOR TREATMENT

Patient's Name____________________________________ **Sex**____________________
Patient's HomeAddres____
City, State,Zip____
Phone_______________________________ **Cellular**____________________________
Social Security#_______-_______-_________ **(for insurance reimbursement)**
Date of Birth ____________________________________ **Age**______________________
Name of Care Facility____
Facility Address____
City, State, Zip____
Phone____
Facility Contact_____________________________________ **Title**___________________

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. We realize that these laws are complicated, but we must provide you with the following important information that 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/dental 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 to ensure that the dentist has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information periodically to another dentist, physician or health care provider who becomes involved in your case.

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 you health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

Name of Responsible Party:____
Relationship_______________________________ **Email**___________________________
Phone:____________________ **Cellular**____________________________ **Fax**______________
Mailing/Billing Address____
City, State, Zip:____

How did you hear about Pure Smiles Dental Hygiene? _______________________________
To Whom may we thank for referring you to us? ___________________________________

ALL FEES ARE ULTIMATELY THE RESPONSIBILITY OF THE RESPONSIBLE PARTY. We are a fee for service practice and ALL FEES ARE DUE PRIOR AT TIME OF SERVICE. As a courtesy we will bill your insurance to reimburse you for any reimbursement allowed. They will be mailed directly to you.

Permission Granted for Review of Medical Records.
Permission Granted to communicate medical information via email.
Permission Granted to take pictures of patient for chart identification and educational purposes.
An associated RDHAP may be the provider of dental hygiene services.

Signature of Responsible Party____________________________________ **Date**____________

Signature Power of Attorney for Health _______________________________ **Date**____________