PURE SMILES MOBILE DENTAL HYGIENE
Practice of Jayme Daley, RDH, RDHAP#544
6680 Alhambra Ave. #159 Martinez, Ca. 94553
925-233-6888 Fax 925-848-3688
PureSmilesDH@gmail.com www.PureSmilesDentalHygiene.com

Patient Name_____ **Date of Birth**_____
Facility Name_____ Facility Contact _____
Facility Address _____ Room# _____
Facility Phone number _____ Email _____
Responsible Party name _____
Responsible Party Address _____
Responsible Party Phone Number _____ Email _____

DENTAL HISTORY

Antibiotic pre-medication needed prior to dental treatment? Yes ___ No___ Unknown ___
Reason for today's dental visit? _____
Name of Dentist _____ City _____ Phone _____
Date of last cleaning? _____ Any Dental Pain or issues? _____

MEDICAL HISTORY

PHYSICIANS NAME _____ KAISER# (If applicable) _____
Address _____
Phone number _____ Fax number _____
Please describe current medical condition or long-term disability if any

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PLEASE CHECK ANY OF THE FOLLOWING: ____ Ambulatory ___ Walker ___ Wheelchair___ Bedridden

__ ARTHRITIS	__ DEAF/HEARING IMPAIRED	__ PACEMAKER
__ARTIFICIAL HEART VALVES	__ DEMENTIA	__ HIGH BLOOD PRESSURE
__ARTIFICIAL JOINTS	__ PARKINSON	__ HEPITITIS
__ ASTHMA	__ DIABETES	__ HIV/AIDS
__ BLIND	__ COUGH, PERSISTENT	__ STROKE
__ BACK PROBLEMS	__ TUBERCULOSIS	__ SHORTNESS OF BREATH
__ CANCER	__ EPILEPSY/SEIZURES	__ RESPIRATORY DISEASE
__ CHEMOTHERAPY	__ CONGESTIVE HEART FAILURE	__ TUBERCULOSIS
__ RADIATION TREATMENT	__ MITRAL VALVE PROLAPSE	__ OTHER_____

ALLERGY TO ANY MEDICATION, ANESTHETIC, OR LATEX? _____
LIST CURRENT MEDICTIONS _____
_____
Pharmacy Name _____ Phone Number _____
The above information is accurate and complete to the best of my knowledge. I will not hold Pure Smiles or any staff member responsible for any errors or omissions on the form. All fees are the responsibility of the "RESPONSIBLE PARTY" **ALL FEES ARE DUE AT TIME OF SERVICE.**
Name of RESPONSIBLE PARTY _____ Relationship _____

Signature _____ Date _____

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CONSENT FOR TREATMENT

PATIENT NAME_____ **SEX** _____
Date of Birth _____ Age _____
Facility Name _____
Social Security Number# _____-_____-_____ (only for insurance reimbursement)
Dental Insurance Name/Card Number _____
Name of Primary Policy Holder _____ Date of Birth _____
How did you hear about Pure Smiles Dental Hygiene? _____
To whom may we thank for referring you to us? _ _____

Pure Smiles Dental Hygiene is a fee for service practice. All fees are due at time of service and are the ultimate responsibility of the responsible party. As a courtesy to our patients, we can bill your insurance provider to reimburse you for any reimbursements allowed. Pure Smiles Dental Hygiene does not take on-site x-rays. We Recommend our patients have x-rays and exam in the dental office yearly (if possible).

HIPAA
In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability ACT of 1996 "HIPAA", we are required to maintain the confidentiality of your health information. Your privacy and health is a main concern, and we must provide you with the following information that describes how we may use and disclose your protected heath information to carry out treatment. For payment of health care services and for other purpose 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, health care, and any related services. We may use and disclose your protected health/dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, insurance company, medical professional, dental professional, third party, or responsible party.

Permission granted to consult on your behalf with physician, dental providers, caregivers, responsible party
Permission granted to communicate medical information via email
Permission granted to take picture of patient for chart, consultation/education, and responsible party
An associate RDHAP of Pure Smiles may be the dental provider of dental hygiene services.

Name of Responsible party _____ Relationship_____
Phone number _____ email _____

Responsible party signature _____Date _____

Signature of Power of Attorney for Health _____ Date _____

PURE SMILES
MOBILE DENTAL HYGIENE

Medical Order Request for Dental Treatment

**** TO BE SENT TO YOUR MEDICAL DOCTOR****

Date _____
PATIENT_____ DOB _____
KAISER# IF APPLICABLE_____

Due to patient's health/age and inability to travel to be treated in a Dental office, the patient may have oral dental hygiene services at their residence or facility. Services will be provided by Pure Smiles Dental Hygiene practice of Jayme Daley RDH, RDHAP, and associates.

Please help us with the following medical information.

Is there a need for pre-treatment antibiotic therapy? Yes _____ No _____
If so, what would you like to prescribe? _____
Reason for pre-med_____

Do you recommend any sedation medication for patient comfort, compliance or behavior stability? Yes _____ No _____
If so, what would you like prescribe? _____

Please indicate if any pre or post treatment modification and/or alterations in routine medications prior to dental treatment. _____

Physician's signature_____ DEA# _____

Please Fax back to 925-848-3688 or email PureSmilesDH@gmail.com

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