



THE TOOTH BOOTH

The Tooth Booth - New Patient Medical & Dental History Form

The Booth That Boosts Your Smile

Please complete all sections. Information is confidential and used to provide safe dental hygiene care.

How did you hear about us: _____

Patient Profile:

First Name: _____ Last Name: _____ Preferred Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone:(____) _____ Work:(____) _____ Ext: _____ Cell Phone:(____) _____
Email: _____
Preferred Method of Contact: Home Work Cell Email
Date of Birth: ____/____/____ Age: ____ Gender: Male Female Non-Binary
Emergency Contact Name: _____ Relationship: _____ Tel:(____) _____
Spouse/Partner Name: _____ Tel:(____) _____
Employment Status: Full Time Part Time Retired Other: _____
Occupation: _____ Employer: _____
Do you have dental insurance? Yes No
Is the patient responsible for the account? Yes No

Insurance:
Name of Insured: _____ Relation to Patient: _____
Date of Birth: _____
Insurance Company: _____
Group Number: _____ Policy/Member ID: _____

Responsible Party for Account (if someone other than the patient) Parent Guardian Spouse Other
First Name: _____ Last Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone:(____) _____ Work:(____) _____ Ext: _____ Cell Phone:(____) _____
Date of Birth: _____

Dental History

Name of previous dentist: _____ Location: _____
 When was your last dental visit: _____
 When was your last dental cleaning: _____
 When were your last dental x-rays: _____
 Whats is your chief concern/reason for today's visit: _____

Have you ever had problem with the following:

Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaw clicking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head/Neck muscle fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Head/Neck trauma/injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grinding habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Clenching habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain when biting down	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bad breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bad taste	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Gums	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Periodontal problems/	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loose teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tooth abscess	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Food collection between teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Canker sores	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Crowns/Bridges /Implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reoccurring sore spots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mouth Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chewing habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dry Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity:	<input type="checkbox"/> Cold	<input type="checkbox"/> Heat	<input type="checkbox"/> Sweets		
Dental Anxiety:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	

How often do you brush? _____ Powerbrush Manual
 How often do you floss? _____ Spool thread Flossers Waterpik
 Do you use any self-care aids: Yes No Explain: _____
 Do you wear any appliances: Yes No Explain: _____
 Do you smoke chew tobacco: Yes No If so, How much _____
 Do you Vape: Yes No If so, How much _____
 Do you do marijuana: Yes No If so, How much _____
 Do you consume alcohol: Yes No If so, How much _____

Do you have a family history of Head/Neck/Oral Cancer: Yes No
 Do you like your teeth when you smile: Yes No
 Do you want whiter teeth: Yes No
 Are you interested in Orthodontic treatment in the future (braces): Yes No
 What would you like to improve about your smile: _____

Denture Information (If Applicable)

Full Denture Partial Denture
 How old are your dentures? _____
 Do you sleep with your dentures in your mouth? Yes No
 Any sore spots or concerns? _____
 Do you like your dentures Yes No

Medical History

Although dental personnel primarily treat the area in and around your mouth; your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. This information is always kept confidential as per our privacy policy. Thank you for answering the following questions.

Physician's name: _____ Date of last visit: _____
Physician's address: _____

Are you under a physician's care now:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reason: _____		
Have you ever been hospitalized, treated or had major surgery:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a serious head or neck injury:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a surgery to replace a joint:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been recommended to take antibiotics before a dental appointment:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Allergies:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Environmental
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anaesthetic	<input type="checkbox"/> Nitrous Oxide	
<input type="checkbox"/> Other: _____				

Please indicate if you have any of the following:

<input type="checkbox"/> AIDS/ HIV positive	<input type="checkbox"/> Anemia	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Alzheimer's Disease	
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Angina	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Breathing Issues	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Back Problems	
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Cold Sores	
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Cough	<input type="checkbox"/> Cortisone Medication	<input type="checkbox"/> Contact Lenses	
<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Excessive Thirst	
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Fainting	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Headaches	
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Haemophilia	
<input type="checkbox"/> Hepatitis A,B,C	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Herpes	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Mental Illness.	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Shingles	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Skin Rash	<input type="checkbox"/> Stroke	<input type="checkbox"/> Sickle Cell Disease	
<input type="checkbox"/> Tumour/ Growths	<input type="checkbox"/> Swelling of Limbs	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Tonsillitis	
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	
	<input type="checkbox"/> Other: _____			

Medication List

Medication Name.	For what condition?	Dose/ Frequency?

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform The Tooth Booth of any changes in my health status.

I authorize The Tooth Booth to perform oral health assessments, preventive dental hygiene services, oral hygiene instruction, denture cleaning services, caregiver education, and related procedures as discussed.

Signature: _____ Date: _____

Printed Name: _____



Consent and Authorization

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received or been offered a copy of the dental practice's Notice of Privacy Practices, which explains how my protected health information (PHI) may be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Patient Initials: _____

Consent for Use and Disclosure of Protected Health Information

I voluntarily consent to the use and disclosure of my protected health information by this dental practice for purposes including:

- Providing dental treatment and related healthcare services
- Coordinating care with other healthcare providers
- Processing insurance claims and obtaining payment
- Healthcare operations, including quality assessment, compliance, and administrative functions
- Other uses and disclosures permitted or required by law

I understand that my information may be disclosed as necessary to carry out these activities.

Patient Initials: _____

Communication Authorization

I authorize the dental practice to communicate with me regarding appointments, treatment, billing, and other healthcare matters through:

Phone Calls Voicemail Messages Text Messages Email Postal Mail

Preferred Contact Number/Email:

I understand that electronic communications may involve certain privacy risks despite reasonable safeguards.

Patient Initials: _____

Authorization to Discuss Information with Others (Optional)

I authorize the dental practice to discuss my healthcare information with the following individuals:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

I do not authorize disclosure of my information to any other individual.

Patient Initials: _____

Patient Rights

I understand that I have the right to:

- Request restrictions on certain uses and disclosures of my PHI.
- Request confidential communications.
- Inspect and obtain copies of my health records, subject to applicable law.
- Request amendments to my health records.
- Receive an accounting of certain disclosures of my PHI.
- Revoke this consent in writing, except to the extent action has already been taken in reliance on it.

Patient Initials: _____

Revocation of Consent

I understand that I may revoke this consent at any time by submitting a written request to the dental practice. Revocation will not affect any actions taken before the revocation was received.

Patient Initials: _____

Signature

I have read and understand this HIPAA Patient Consent and Acknowledgment Form. I voluntarily agree to the use and disclosure of my protected health information as described above.

Patient Signature: _____

Printed Name: _____ **Date:** _____

If Patient Is a Minor or Incapable of Signing

Parent/Legal Guardian/Personal Representative Name: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____



DENTAL OFFICE FINANCIAL & INSURANCE POLICY AGREEMENT

Patient Name: _____ Date of Birth: _____

Insurance Benefits

Welcome, Thank you for choosing our mobile dental hygiene practice. This agreement outlines our financial policies and your responsibilities regarding payment for dental services and insurance claims. Please read carefully and sign below.

Insurance Courtesy Filing

As a courtesy, our office will submit insurance claims on your behalf when complete and accurate insurance information is provided.

Please note:

- Insurance policies vary significantly in coverage.
- We cannot guarantee payment by your insurance carrier.
- Estimated patient portions are based on information available at the time of treatment.
- Insurance estimates are not guarantees of coverage.

Patient Initials: _____

Patient Responsibility

The patient understands and agrees that:

- The patient is ultimately responsible for all fees incurred for dental treatment.
- Insurance estimates are not guarantees of payment.
- Any portion not paid by insurance is the patient's responsibility.
- Co-payments, deductibles, and non-covered services are due at the time services are rendered unless other arrangements have been approved.

Patient Initials: _____

Estimated Patient Portion

Any deductible, co-payment, co-insurance, or estimated uncovered amount is due on the date of service unless alternative arrangements have been approved.

If insurance pays less than anticipated, the remaining balance becomes the responsibility of the patient.

If insurance pays more than anticipated, any credit balance will be refunded or applied to future services.

Patient Initials: _____

Non-Covered Services

The patient understands that certain procedures may not be covered by insurance, including but not limited to:

- Cosmetic procedures
- Certain elective treatments
- Services exceeding plan limitations
- Procedures deemed not medically necessary by the insurer

The patient agrees to pay for all non-covered services.

Patient Initials: _____

Insurance Claim Follow-Up

Our office will assist with claim submission; however, the patient remains responsible for monitoring insurance claim status.

Any balance remaining unpaid by insurance after 30 days from claim submission may be transferred to patient responsibility and become due immediately.

Patient Initials: _____

Assignment of Benefits

- I authorize payment of dental insurance benefits directly to the dental practice for services rendered.
- I understand that if insurance payments are made directly to me, I remain responsible for payment of my account balance.

Patient Initials: _____

Authorization to Release Information

I authorize the release of any information necessary to process insurance claims and secure payment of benefits.

This authorization includes treatment records, diagnostic findings, radiographs, and other information required by my insurance carrier.

Patient Initials: _____

Claims and Outstanding Balances

Any balance remaining after insurance processing is due within _____ days of notification.

Accounts with unpaid balances may be subject to collection procedures as permitted by law.

Patient Initials: _____

Missed Appointment Policy

Appointments canceled with less than 48 hours' notice or missed appointments may be subject to a fee of \$ 50.00.

Patient Initials: _____

Authorization of benefits

I authorize my insurance company to pay benefits directly to the dental practice for services rendered.

I understand that assignment of benefits does not relieve me of financial responsibility for any unpaid balance.

Patient Initials: _____

Authorization to Release Information

I authorize the dental practice to release information necessary to:

- Process insurance claims
- Obtain pre-authorizations
- Verify insurance benefits
- Collect payment for services rendered

This authorization remains valid until revoked in writing.

Patient Initials: _____

Treatment and Consent

I understand that dental treatment recommendations are based on professional clinical judgment and are independent of insurance coverage determinations.

I accept financial responsibility for treatment that I choose to receive.

Patient Initials: _____

Acknowledgment and Agreement

I have read, understand, and agree to the Financial Responsibility & Insurance Agreement. I understand that I am ultimately responsible for payment of all dental services provided.

Patient Name (Print): _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Information (if applicable)

Name: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____

Office Use Only

Staff Member: _____

Date Reviewed: _____

Notes: _____