SHINE DENTAL HYGIENE
Katerina T. Pritchett, RDHAP #713

Patient Health Information

Patient Name _____ DOB _____

Home Address _____

City/State/Zip _____

Phone # _____ SSN _____ Medi-Cal # _____

Email Address _____

Insurance Provider _____ Group # _____

Facility Name & Contact _____

Facility Address _____

City/State/Zip _____ Facility Phone _____

Responsible Party Name _____ Relationship to Patient: _____

Emergency Contact _____ Emergency Contact Phone _____

Dental History

Dentist Name _____ Phone _____

Dentist Address _____ Date of last visit _____

Reason for today's visit _____

CIRCLE IF YOU'VE HAD PROBLEMS WITH ANY OF THE FOLLOWING

Bad breath or taste	Dry mouth	Mouth sores	Sensitivity to biting
Bleeding gums	Growths in mouth	Growths in mouth	Food collection between teeth
Broken fillings	Loose teeth	Sensitivity to hot/cold	

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Patient Health Information cont'd

Medical History

Primary Care Physician _____ Phone _____

Physician Address _____

Antibiotic Premedication needed for dental treatment in the past? Yes ____ No ____ Unsure ____

Circle all that Apply:

Alzheimer's Disease	Chemotherapy	Headaches	Pacemaker/Difibulator
Anemia	Circulatory Problems	Heart Murmur	Parkinson's Disease
Arthritis	Cortisone Treatments	Heart Problems	Persistent Cough
Artificial Joints	Cough up Blood	Hemophilia	Radiation Treatment
Artificial Heart Valve	Deaf	Hepatitis	Respiratory Disease
Asthma	Dementia	HIV/AIDS	Rheumatism
Back Problems	Diabetes	JawPain	Shortness of Breath
Blindness	Epilepsy/Seizures	Kidney Disease	Stroke
Blood Disease	Fainting	Liver Disease	Swelling of Feet/Ankles
Cancer	Glaucoma	Mitral Valve Prolapse	Thyroid Problems

Specify any allergies _____

List medications currently taking _____

_____

_____

Preferred Pharmacy _____

Pharmacy Address _____

The above information is accurate and complete to the best of my knowledge.
I will not hold Shine Dental Hygiene or any member of it's staff responsible for any errors or omissions that I have made in the completion of this form.

Responsible party signature _____ Date _____

Printed name _____ Relationship to patient _____

SHINE DENTAL HYGIENE
Katerina T. Pritchett, RDHAP #713

Consent for Treatment

Patient Name _____ DOB _____

Facility or Home Address _____

City/State/Zip _____ Home Phone # _____

Facility Name & Contact Person_____ Facility Phone _____

Responsible Party Name _____ Relationship to Patient _____

Primary Care Physician _____ Phone _____

Dentist Name _____ Phone _____

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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. This describes how we may use and disclose your protected 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 information to provide, coordinate, or manage your dental care and any related services. For example: your dental/health information may be provided to a dentist to whom you have been referred. In addition, we may disclose your protected health information periodically to another dentist, physician, or health care provider who becomes involved in your care. 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 your health plan about a treatment you are going to receive to obtain prior to approval or to determine whether your plan will cover treatment.

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Consent for Treatment Cont'd

_____ INITIALS *I have reviewed the Privacy Practices above & give consent for dental hygiene treatment and preventative treatment for the patient

_____ INITIALS *Permission is given to review medical records

_____ INITIALS *Permission is granted to take photos for chart ID or educational purposes

_____ INITIALS *All fees are ultimately the responsibility of the "Responsible Party"

_____ INITIALS *Full payment is required at the time of service, unless arrangements are made prior

Responsible party signature _____ Date _____

Billing Address _____

City/State/Zip _____

Phone # _____ Email address _____