ROVING DENTAL HYGIENE

Registration Form

Email karen@rovingdentalhygiene.com Website www.rovingdentalhygiene.com
Phone 613-770-3801

Patient Information

Patient's Name_____M_____F_____

Birthdate_____

Name of Care Facility_____ROOM#_____

Main PSW's_____

Physician_____Dentist_____

Power of Attorney Name/Contact Info_____

Email_____Phone #_____

Preferred method of communication Text Email Phone Call _____

To whom may we thank referring you to us?_____

Consent for Treatment

I authorize dental hygiene services for_____. I also give my consent to any advisable and necessary treatment by Roving Dental Hygiene. I understand and acknowledge that I am financially responsible for the services provided for the above named, regardless of insurance coverage. I understand that payment is due upon the date of hygiene services. Permission is granted for review of medical records.

Power of Attorney for Health Care_____|_____
Name Signature

Relationship to Patient_____

Insurance Information

Card Holder's Name: _____Date of Birth_____

Name of Insurance Company:_____

Group #_____ID#_____

Relationship to Patient:_____

Home Address_____

In accordance with the Personal Health Information Protection Act (PHIPA) Bill 31 , Nov. 2004**,** we are required to maintain the confidentiality of your health 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 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 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 approval or to determine whether your plan will cover treatment.

Medical History

Please circle/check all that apply

Premedication needed (antibiotics before dental treatment), Reason?_____

Artificial Heart Valve

Artificial Joint/Hip/Knee Replacement-Date_____

Bleeding Problem

Heart Attack/Failure

Stroke

Heart disease

Lung Disease

Asthma

Pacemaker

Seizures

Requires Dialysis

Diabetes Type_____

Hepatitis A B C

Kidney Disease

Blood Pressure - High Low Normal

Thyroid Disease

Bleed easily

Cancer - Radiation/Chemotherapy

Alzheimer's/Dementia

Allergies?_____

Describe current or long term disability / medical condition_____

Describe any medical conditions not listed above_____

Current List of Medications_____

Signature_____**Date**_____