

	Registration Fo	<u>orm</u>	
Email karen@rovingdentalhygiene.com Phone 613-770-3801		Website w	vw.rovingdentalhygiene.com
Patient Information			
Patient's Name			MF
Birthdate			
Address			
Email	Phone _		
Preferred Method of Communication	Email	Phone	eText
To whom may we thank referring you to us?			
Insurance Information			
Card Holder's Name:		_Date of Birth	
Name of Insurance Company:			
Group #	ID#		
Relationship to Patient:			

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 bef	ore 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				
Signature	Date			