Roving Dental Hygiene

rovingdentalhygiene@gmail.com
613-770-3801
www.mobilehygiene.ca

Patient Information

Patient's Name_____M_____F_____

Home Address_____Phone #_____

Birthdate_____

Name of Care Facility_____ROOM#_____

Facility Contact Person_____Title_____

Physician_____Dentist_____

Power of Attorney Name/Contact Info_____

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:_____

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?_____

Bleeding Problem	Excessive Thirst	Pain in Jaw Joints
Heart disease	Heart Murmur	Heart Attack /Failure
Recent Weight Loss	Artificial Joint /hip/knee	Irregular Heartbeat
Congenital Heart Disorder	Angina /Chest Pain	Artificial Heart Valve
Pacemaker	Shortness of Breath	Seizures
Diabetes Type____	Lung Disease	Breathing Problem
Recent Blood Transfusion	Asthma	Emphysema
HIV Positive/AIDS	Drug/Alcohol Addiction	Stroke
Hepatitis A B C	Requires Dialysis	
Blood Pressure - High Low Normal		Bleed easily
Kidney Problems	Thyroid Disease	Kidney Disease
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**_____