DENTAL HYGIENE CLIENT INFORMATION

CLIENT NAME: _____ **Date of Birth (dd/mm/yy):** _____

Please complete the following information in its entirety, including signatures of client or person legally responsible for client. (Please print clearly):

Client is an Adult ☐ Child (under18years) ☐

Address: _____
Street # Street Name Unit # City Postal Code

Client Phone #: _____ home ☐ cell ☐

Email address: _____

Long term care or hospital facility: _____ Room #: _____

Family Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Power of Attorney/Guardian Name: _____

Relationship to Client: _____ *Phone* _____

Email: _____ *home* ☐ *cell* ☐

Do you have a hip/knee or joint replacement, or require antibiotics prior to dental cleanings for any other reason?

_____

Please list any mobility issues: _____

Do you have dental insurance: Yes ☐ No ☐

If **YES** – Policy Holder Name: _____ Date of Birth: _____

Employer: _____

Relationship to client: _____ Insurance Company: _____

Policy /Group # _____ I.D. or certificate # _____

Person responsible for payment of account: _____ Relationship: _____

Phone # Home: _____ Work: _____ Cell: _____

Employer: _____ Payment preference: Cash ☐ Cheque ☐ Credit Card ☐

Best time for appointments: Morning ☐ Afternoon ☐ Either ☐

Primary Contact Person: _____ Relationship _____

Address: _____

Phone #: Home: _____ Work: _____ Cell: _____

Signed: _____ Print Name: _____ Date: _____

ACCOUNTS ARE DUE WHEN SERVICES ARE RENDERED. FOR YOUR CONVENIENCE PAYMENT MAY BE MADE BY CREDIT CARD OVER THE PHONE.

NEW CLIENT INFORMATION FORM (continued ➔)

If you have ANY questions regarding the medical or dental questionnaire, please call us at 905-371-4454 or email us at kristie@smilesformilesmobile.ca

Smiles for Miles
Mobile Dental Hygiene Services

FINANCIAL AGREEMENT

Thank you for choosing us to provide dental hygiene care for the person listed on the reverse side of this form. We consider it an honour to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our office.

PAYMENT POLICY

- Payment for services is expected the day of treatment (unless otherwise arranged).
- We accept cash, cheque and credit cards (Visa, MasterCard, AMEX and Discover).
- Also, we are happy to submit dental insurance claim forms on your behalf and accept assignment of benefits. It is your responsibility to pay your portion of the fees at the time of service.

If you have pre-arranged to pay by cheque, a statement will be mailed to you, and payment is expected within 14 days of the statement. If payment is late more than 3 times, we will no longer accept payment by cheque. A $45.00 charge will apply when a cheque is returned by the bank for any reason.

DENTAL INSURANCE

- In order for us to complete the insurance claim form for you, you must provide us with the insurance information, including insurance company, group and ID number, and any other information necessary to verify the client's coverage and to file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and the client, not the insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another. We adhere to the current Ontario Dental Hygienists' Association Fee Guide.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits, as well as benefit amounts, limitations, exclusions, waiting periods, etc., is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for non-payment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for services are due at the time of Treatment, unless otherwise agreed upon.

**** Please note that some insurance companies will not pay for independent dental hygiene services. Although this is rare, if you are unsure if your policy will pay for dental hygiene services by an independent dental hygienist, please check with them before the appointment.**

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

CONSENT & AUTHORIZATION: I authorize dental treatment on _____
(Name of Client)

and agree to pay all related professional fees. I have read and understand this document in its entirety, outlining office policies and financial policies of Smiles for Miles - Mobile Dental Hygiene Services. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:

Print Name_____ Signature_____

Relationship to Client_____ Date_____

Are you the person legally responsible for this client? Yes ☐ No ☐

Reviewed by Treating Dental Hygienist_____ Date _____

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Smiles for Miles
Mobile Dental Hygiene Services

DENTAL HISTORY

CLIENT NAME: _____

When was your last visit to the dentist (approximately): _____

What was it for: _____

When was your last professional dental cleaning: _____

Approximately when were your last dental radiographs (x-rays): _____

How often do you receive dental treatment, or dental hygiene care: _____

Are you under the care of a dental specialist? (ie: orthodontist, endodontist, prosthodontist, periodontist) _____

	Yes	No	Not Sure
Do you have any growths or sore spots in your mouth?	☐	☐	☐
Have you ever been diagnosed with periodontal/gum disease?	☐	☐	☐
Have you ever been advised to take antibiotics prior to dental cleanings? If yes, why? _____	☐	☐	☐
Do you have prolonged bleeding if you cut yourself, or are you on a blood thinner? If yes, please explain: _____	☐	☐	☐
Do you have any present dental problems? (sore gums, sensitive teeth, bleeding, bad breath etc.) If yes, please describe: _____	☐	☐	☐
Are you nervous during dental treatment?	☐	☐	☐
Do you grind or clench your teeth while awake or asleep?	☐	☐	☐
Have you ever had dental implants done to replace missing teeth or to hold a denture?	☐	☐	☐
Do you currently have dentures – full or partial?	☐	☐	☐

Do you have or have you ever experienced any of the following (please circle which ones):

- sensitive teeth (hot or cold) • cold sores • bleeding gums when brushing • sore gums • mouth sores
- loose teeth • dry mouth • recession • bad breath • swelling in your mouth or face area
- difficulty chewing • sore jaw • jaw clicks or pops on opening or closing • difficulty swallowing
- burning sensation • calculus (tartar build-up) • toothache • fractured or broken filling
- tooth infection (abscess) • yellow or discolouration of teeth • accident, injury or surgery to face, jaw or teeth

Are you having any problems with your teeth or mouth that are not mentioned above, or is there any additional information or comments you would like to add? _____

_____

_____

Form completed by:

Print Name_____ Signature_____

Relationship to Client_____ Date_____

Are you the person legally responsible for this client? Yes ☐ No ☐

Reviewed by Treating Dental Hygienist_____ Date _____

Smiles for Miles
Mobile Dental Hygiene Services

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MEDICAL HISTORY

CLIENT NAME: _____

MEDICAL ALERT: _____

Although dental hygienists 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 dental hygiene care you will receive. Thank you for answering the following questions.

Are you being treated for any medical condition at the present or within the last year? ☐ Yes ☐ No

If so, why? _____

Has there been any change to your general health in the past year? ☐ Yes ☐ No

If yes, please explain: _____

Do you have, or have you been informed that you had any of the following:

	Yes	No		Yes	No
Heart Condition	☐	☐	Stomach or Intestinal Disease	☐	☐
Heart Attack	☐	☐	Pacemaker	☐	☐
High Blood Pressure	☐	☐	Artificial Joints (knee, hip...)	☐	☐
Stroke	☐	☐	Epilepsy or Fainting	☐	☐
Angina	☐	☐	Glaucoma or Eye Problems	☐	☐
Sinus Trouble	☐	☐	Hepatitis A/B/C/D	☐	☐
Steroid Therapy	☐	☐	Cancer	☐	☐
Hemophilia/ Excessive Bleeding	☐	☐	Radiation/Chemotherapy	☐	☐
Cold Sores	☐	☐	Tuberculosis	☐	☐
Thyroid Problems	☐	☐	AIDS or HIV	☐	☐
Diabetes	☐	☐	Mitrovalve Prolapse	☐	☐
Heart Murmur	☐	☐	Hormonal Imbalance	☐	☐
Artificial Heart Valve	☐	☐	Kidney Problems or Dialysis	☐	☐
Thrush	☐	☐	Alcohol or Drug Addiction	☐	☐
Alzheimer's or Dementia	☐	☐	Respiratory / Asthma	☐	☐
Arthritis	☐	☐	Digestive Disorders/Acid Reflux	☐	☐
TMJ Disorder	☐	☐	Rheumatic Fever	☐	☐
Sleep Apnea	☐	☐	Women : Are you pregnant?	☐	☐

Please list ALL allergies (including medications):_____

Are you allergic to Latex: Yes ☐ No ☐ Any other allergies: _____

Have you ever had any adverse reactions to any medicines, injections or anaesthetics? Yes ☐ No ☐

If yes, please explain: _____

Current Medications: _____

_____

(Please list ALL medications you take, including vitamins & herbal supplements. List on separate sheet if necessary).

Have you been hospitalized in the past 2 years for any reason? Yes ☐ No ☐

If yes, for what: _____

Do you smoke or use tobacco products: Yes ☐ No ☐ # years: _____ how often?:_____

Are there any conditions or diseases not listed above that you have or have had? Yes ☐ No ☐

If yes, please list: _____

MEDICAL HISTORYFORM (continued ➔)

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Smiles for Miles
Mobile Dental Hygiene Services

MEDICAL HISTORY page 2

CLIENT NAME: _____

Certain medical conditions require antibiotic coverage before receiving dental hygiene care. If you have had any of the following, or if you have ever been advised that you require antibiotics prior to dental treatment, **please advise us immediately**.

- prosthetic heart valves,
- a prosthetic joint replacement within 2 years,
- previous bacterial endocarditis,
- unrepaired cyanotic congenital heart disease including palliative shunts and conduits, completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first 6 months after the procedure,
- repaired congenital heart defect with residual defects at the site or adjacent to the site of a prosthetic device
- cardiac transplantation recipients who develop cardiac valvulopathy

Please let us know if any of the conditions listed pertain to you. We may need to get an order from your physician or dentist for antibiotics and permission to carry out dental hygiene care. Please advise us PRIOR to your first appointment.

GENERAL RELEASE (Please sign after completing medical and dental history forms).

I, the undersigned, certify that I have provided an accurate and complete personal, medical and dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history**. Should there be any change in either the health status or any other information I have provided, I will advise this dental hygiene office.** I authorize the dental hygienists to perform procedures as may be required to determine necessary treatment and then to provide the necessary treatment. I give consent for Smiles for Miles to discuss my medical or dental health with any and all of my health providers they deem necessary to properly treat me. I give consent for my dentist, doctors, and other health care providers, including nursing home staff to release any of my medical/dental information to Smiles for Miles. I give consent for Smiles for Miles to send my insurance company my dental claims electronically or by mail, and to discuss any aspect of my dental care with the dental claims department, with regards to any dental claims submitted for me – whether the claim is assigned to them or not. Privacy of your personal information is an important part of our office providing you with quality dental hygiene care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. I have been advised that the privacy policy of Smiles for Miles is available online at www.smilesformilesmobile.ca or that I may call or write and request a copy of the same at any time. I understand that my personal information will be collected, used and disclosed within the guidelines of this policy. I understand that responsibility for payment of the dental hygiene services for myself or my dependents is mine, and I assume responsibility for fees associated with these services.

_____ _____

Signature as: Client ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Date consent signed

_____

(Print Name)

Reviewed by Treating Dental Hygienist:_____ Date:_____

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