Smiles By Diana – Mobile Dental Hygiene Outreach Service
Diana L. Carr, RDHAP Ca. Lic# HAP135
P.O. Box 264
San Juan Bautista, CA 95045-0264
831.623.4585 Fax: 831.623.4350
EMAIL: Diana@SmilesByDiana.com

PATIENT REGISTRATION

Date:_____

Patient Name: _____

Facility Name (if applicable): _____

Address: _____

City, State, Zip:_____ Sex: Male ____ Female ____

Home Phone: _____Mobile Phone: _____E-Mail: _____

Marital Status: Single __ Married ___ Divorced ___ Widowed ___

Date of Birth: _____ Age: ____ Social Security # _____

INSURANCE INFORMATION

Dental Insurance Provider: _____
(Please provide copy of insurance or Medi-Cal card both front and back)

Name of Subscriber: _____ Subscriber DOB: _____

Subscriber ID: _____ Group ID: _____

PRIMARY CARE PHYSICIAN

Primary Care Physician _____

Address: _____

City, State, Zip: _____ Phone: _____

RESPONSIBLE PARTY CONTACT INFORMATION

Name & Relationship of Responsible Party: _____

Address: _____

City, State, Zip: _____

Telephone: (H)_____ (W) _____ (C)_____

Who may we thank for referring you? _____

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MEDICAL HISTORY

Please circle

Yes	No	Are you in good health?
Yes	No	Are you under a doctors care now?
Yes	No	Have you been hospitalized in the last two years?
Yes	No	Are you taking any medications, pills, or drugs? (***see medication sheet***)
Yes	No	ARE YOU ALLERGIC TO ANY MEDICATION OR SUBSTANCE?

Please circle any of the following applicable health conditions:

Heart trouble	**Artificial heart valve**	**Current or previous endocarditis**
Heart surgery	Heart Pacemaker	Mitral Valve Prolapse
Chemotherapy	Radiation treatment	Cancer
Blood Disease	HIV/AIDS	High or Low Blood Pressure
Hemophilia	Excessive Bleeding	Kidney Disease
Liver Disease	Lung Disease	Tuberculosis
Head Injury	Counseling	Dementia/Alzheimer's Disease
Picks Disease	Hepatitis	Epilepsy/Seizure Disorder
Artificial Joints	Jaw Pain	Cortisone Medication
Stroke	Diabetes	Parkinson's Disease
Cerebral Palsy	Allergies (specify) _____	

Have you been advised by your doctor to take antibiotic pre-medication prior to your dental appointments? _____

Please Read and Sign

I authorize the release of any medical or other information necessary to process claims for payment. Medi-Cal, Share-of-cost Medi-Cal, Patient Trust Accounts or Private Dental Insurance may be billed for Dental Hygiene Treatment. I authorize payment of third party payment (dental benefits) directly to Diana Carr, RDHAP, dba Smiles by Diana. I understand that payment is expected when services are rendered unless insurance coverage is in effect. A balance may remain after the insurance carrier has paid. I understand that this remaining balance is the financial responsibility of the above named responsible party. All fees are due in 30 days from date of invoice. After 30 days a $10 per month re-bill / late fee will be assessed.

Type of Billing (please check one): Private Funds _____ Medi-Cal _____ Dental Insurance _____

Medi-Cal Coverage for dental hygiene is usually once per full 12-month period. Special conditions and/or medications may determine more frequent treatment. Permission is granted to use Medi-Cal Share of cost funds if available.
I hereby grant authority to Diana Carr, RDHAP to perform dental hygiene procedures that may be necessary or advisable for treatment planning and completion of dental hygiene for the above named patient.

SIGNED: _____ DATE: _____

Authorization must be signed by the patient or by the responsible party in the case of a minor or when the patient is physically or mentally incompetent.

_____ _____
SIGNATURE OF POWER OF ATTORNEY OF HEALTH CARE DATE