Hood River
MOBILE
Dental Hygiene

Name_____
Last First MI

Preferred Name: _____ □ Male □ Female

DOB ___/___/_____ Age_____

Address:_____

City_____ State_____ Zip_____

Home Phone_____ Work_____ Cell_____

Email Address: _____

Name of Patients Care Facility (*if applicable*)_____

Power of Attorney (*if applicable*)_____ Phone_____

How would you prefer to have appointments confirmed? Home Work Cell Text Email

Marital Status: □Single □Married □Divorced □Widowed

Name of Spouse/Partner_____

Whom may we thank for referring you? _____

Emergency Contact Name_____

Relationship to patient_____Phone _____ Home Work Cell

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Financial and Treatment Consent

The information on this page is correct to the best of my knowledge. This includes any medical history on the health history form. I understand it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services with my informed consent that I may need during diagnosis and treatment. I authorize Hood River Mobile Dental Hygiene to release dental/medical information to other health care professionals when needed. I understand that I am responsible for all costs of dental treatment. I understand appointments are specifically reserved for me and last minute cancellations are disruptive to Hood River Mobile Dental Hygiene's office and unfair to other patients who may have wanted the allotted time. I agree to give a minimum of 24 hour notice of cancellation or change of appointment.

Patient Signature_____ Date_____

Parent or Guardian

Acknowledgement of Receipt of Notice of Privacy Practices

A copy may be given for your review upon request

I, _____, have read, and/or received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____ _____

Signature Date