KIMBERLY SWANSON, RDHAP

Registered Dental Hygienist in Alternative Practice #1009

951.267.7727 kswansonrdhap@gmail.com

PATIENT INFORMATION

Please Print Dr. Mr. Mrs. Ms.

Patient Name ______________________________ Date of Birth ______________

Home Address ______________________________ Phone Number ______________

City, State, Zip Code ______________________________ SS# ______________

Physician's Name ______________________________ Phone Number ______________

Physician's Address ______________________________

Facility Name ______________________________ Phone Number ______________

Facility Address ______________________________

Pharmacy Name ______________________________ Phone Number ______________

Pharmacy Address ______________________________

Dentist's Name ______________________________ Phone Number ______________

Dentist's Address ______________________________

Date of Last Dental Exam ______________________________ Last Dental Cleaning ______________

Name of person who is responsible for medical and health related decisions ______________________________

Address ______________________________ Phone Number ______________

Name of person who referred you ______________________________

Payment Information

At Kimberly Swanson RDHAP, we are determined to charge fair and reasonable fees for our unique service. We work on a Fee-For-Service basis and payment is charged directly to the patient. Payment is required the day treatment is rendered. We are not contracted with with any PPO plans are not a provider of Medical, Medicaid, HMO or DMO. We accept Venmo, Zelle, and most credit cards.

Health History

Certain illness and medications may indicate an alteration to your treatment. In order to provide the best and safest possible care, please complete the following:

Condition		
Antibiotic Premedication Prior to Dental Treatment	Y	N
Joint Replacement	Y	N
Date of Surgery ______________		
Diabetes	Y	N
Diet Drug	Y	N
Kidney Disease	Y	N
Hives or Rash	Y	N
Rheumatic Fever / Rheumatism	Y	N
Asthma	Y	N
COPD	Y	N
Shortness of Breath	Y	N
Autoimmune Disorder	Y	N
Heart Disease	Y	N
Heart Murmur	Y	N
Mitral Valve Prolapse	Y	N
High Blood Pressure	Y	N
Heart Attack	Y	N
Date of most recent ______________		

Condition		
Stroke	Y	N
Date of most recent ______________		
Pacemaker	Y	N
HIV	Y	N
Arthritis or Joint Pain	Y	N
Osteoporosis	Y	N
Liver Disease	Y	N
Hepatitis	Y	N
Blood Disorders	Y	N
Excessive bleeding	Y	N
Glaucoma	Y	N
Mental Disorders	Y	N
Alzheimer's Disease / Dementia	Y	N
Nervous Disorders	Y	N
Parkinson's Disease	Y	N
Cancer	Y	N
Radiation Treatment	Y	N
Chemotherapy	Y	N
Thyroid Disease	Y	N

Condition		
Gastrointestinal Issues	Y	N
GERD/Reflux	Y	N
Ulcers	Y	N
Head Injuries	Y	N
Seizures / Epilepsy / Fainting	Y	N
Substance Abuse	Y	N
Women only: Are you pregnant or nursing?	Y	N

Please list any other health issues or concerns that are not listed above:

____

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Are you allergic to any of the following:

Allergy		
Penicillin	Y	N
Sulfa drugs	Y	N
Tetracycline	Y	N
Dental anesthetic	Y	N
Aspirin	Y	N
Erythromycin	Y	N
Latex	Y	N

Other: ______________________________

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PATIENT INFORMATION - CONTINUED

Please list any medications you currently take (including prescription and over the counter, vitamins, supplements or recreational drugs):

____

____

____

Patient Consent: I agree to the release of my medical/dental information to Kimberly Swanson RDHAP.

Patient/Guardian
Signature:____ Date:____________________

Please return signed copy to Kimberly Swanson at email: kswansonrdhap@gmail.com