MYRDHAP

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Patient Information

Patient'sName:_____Sex_____

Home Address: _____

City, State, Zip: _____

Social Security # : _____Birthdate: _____ Phone: (_____)_____

Name of Care Facility: _____

Address:_____

Contact Name: _____ Title:_____

Name of Physician or Staff Physician: _____

Address: _____

Physician's Phone: (_____)_____ Physician's Fax: (_____)_____

Medicine currently taking: _____

Describe current or long-term disability/medical condition:_____

Please check all that apply:

Breathing Problems	☐	High Blood Pressure	☐	Multiple Sclerosis	☐
Heart Condition	☐	Mitral Valve Prolapse	☐	Blindness	☐
Heart Murmur	☐	Hip/Joint Replacement	☐	Deaf	☐
Heart Pacemaker	☐	Hepatitis	☐	Parkinson's Disease	☐
Hemophilia	☐	Epilepsy or Seizures	☐	Cancer	☐
H.I.V. Positive	☐	Stroke	☐	Type:	
Diabetes	☐	Alzheimer's Disease	☐	_____	
Dementia	☐	Radiation Therapy	☐	Walker/Wheelchair assistance	☐
Allergies	☐	Cerebral Palsy	☐		

LIST ALL & SPECIFY ANY ALLERGIES: _____

_____

Delta Dental and Denti-Cal are accepted however, I require payments upfront. As a courtesy, We will submit a superbill when you get one from the insurance company.

Type of Billing: ☐ Private Funds ☐ Delta Dental ID _____

Please attach BOTH SIDES of Delta Dental Benefits Identification card.

Phone # on back of card_____

Estimated Date of last dental cleaning: _____

Name of Dental Insurance: _____
Group Name: _____
Group #: _____
Send Claims to (address on back of dental card):
_____

_____

_____

Name of Primary Insured: _____ Relationship to Patient: _____

Social Security # of Primary Insured: _____ Date of Birth of Primary Insured: _____

Dental Insurance Phone Number (for eligibility and claim information): _____

All information regarding dental insurance is necessary.
If information is not completed, the treatment may be delayed or you may be billed directly.

In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 14996 (HIPPA), we are required to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following 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 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 heath care provider who becomes involved in your care.
We may use said disclosed 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.
Permission Granted for Review of Medical Records. An associate RDHAP may be the provider of in-home dental hygiene services. Permission Granted to Take Pictures of Patient for Chart Identification and Educational Purposes. Permission Granted for Yearly Dentist Visit.

Name of Responsible Party: _____ Phone: _____

Mailing/Billing Address: _____ Cell phone: _____

City, State, Zip: _____ Relationship to patient: _____

If you want results and progress comments emailed to you, please include email:
Email address: _____

All fees are ultimately the responsibility of the "Responsible Party."
All fees are due in 30 days from date of invoice. Payments can be made via Zelle, Venmo, Check, or Credit Card.

Signature of Responsible Party: _____ Date: _____

Signature of Power of Attorney for Health Care: _____ Date: _____

PLEASE SEND THIS DOCUMENT VIA EMAIL TO MYRDHAP: info@myrdhap.com