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Smiles at Home
Dental Hygiene Practice of Ilene Kendrick RDHAP

New Patient Packet

Please complete the applicable sections before your first appointment. If you need help, a caregiver or authorized representative may assist. Please answer as accurately as possible and tell us if anything changes.

Patient name: _____

Date of birth: _____ Date completed: _____

Packet checklist
□ Patient information and emergency contact
□ Medical history and medication list
□ Dental history and current concerns
□ Consent for dental hygiene services
□ Notice of Privacy Practices and acknowledgment
□ Financial and appointment policies
□ Caregiver/representative communication preferences (if applicable)
□ Records request/release (if applicable)

Return completed forms directly to Smiles at Home at your first appointment. Do not submit completed health forms through a public website form or ordinary email unless you have been informed of the risks and agreed to that method.

NOTICE OF LICENSURE

Dental Hygiene Board of California
NOTICE:
Dental Hygienists in Alternative Practice are licensed and regulated by the Dental Hygiene Board of California
(916) 263-1978
www.dhbc.ca.gov



Patient Information

Full legal name: _____
Preferred name: _____ Date of birth: _____
Preferred language: _____
Home address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ □ Mobile □ Home □ Work
Email : _____

May we leave a message identifying Smiles at Home? □ Yes □ No
If no, instructions: _____

Emergency contact (not automatically authorized to receive health information):
Name: _____ Relationship: _____
Phone: _____ Alternate phone: _____

Primary care provider/physician: _____ Phone: _____
Dentist : _____ Phone: _____

Usual care setting: □ Private residence □ Assisted living □ Skilled nursing facility
□ Other: _____
Facility/location name and address, if different:
_____

Person completing this form, if not the patient:
Name: _____ Relationship/role: _____
Phone: _____

Authority, if applicable: □ Parent of minor □ Legal guardian □ Health-care agent

□ Other: _____

Signature: _____ Date: _____

Medical History

Check all that apply and add details. If unsure, write "unsure."

- □ Heart condition/disease
- □ High blood pressure
- □ Stroke/TIA
- □ Diabetes
- □ Asthma/COPD/breathing condition
- □ Sleep apnea
- □ Kidney disease
- □ Liver disease
- □ Cancer/cancer treatment
- □ Immune system condition
- □ Bleeding disorder
- □ Anemia
- □ Osteoporosis
- □ Joint replacement
- □ Seizures
- □ Fainting/dizziness
- □ Memory, communication, mobility, or sensory needs
- □ Anxiety/difficulty tolerating dental care
- □ Infectious disease requiring special precautions (explain below)
- □ Pregnancy, if applicable
- □ Other: _____
- □ None of the above

Details, dates, or current status: _____

_____

Are you under care for a current condition? □ Yes □ No

Provider/reason: _____

Allergies or adverse reactions (medications, latex, materials, etc.):

□ No known allergies □ Yes — substance and reaction: _____

_____

Serious reaction to dental treatment or local anesthetic? □ No □ Yes □ Unsure

Details: _____

Blood thinner or medication affecting bleeding? □ No □ Yes □ Unsure

Medication for osteoporosis/bone health? □ No □ Yes □ Unsure

Prosthetic heart valve, prior infective endocarditis, or clinician-advised antibiotic premedication? □ No □ Yes □ Unsure

Details/instructions: _____

Medication list (prescriptions, OTC medicines, vitamins, supplements; include dose/frequency if known):

_____ _____

_____ _____

_____ _____

□ Current medication list attached.

Recent hospitalizations, surgeries, or major health changes and dates:

_____ _____

_____ _____

Person providing history: _____ Date: _____

I believe this information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

DENTAL HISTORY & CURRENT CONCERNS

Last dental visit: _____ Last cleaning: _____

Current dentist? □ Yes □ No □ Looking for one
Dentist/name/phone, if known: _____

What would you like help with?

□ Routine hygiene care
□ Bleeding gums
□ Bad breath
□ Tooth sensitivity
□ Dry mouth
□ Difficulty brushing/flossing
□ Dentures/partials
□ Dental pain/swelling
□ Loose teeth
□ Broken tooth/filling
□ Help finding a dentist
□ Caregiver education
□ Other: _____

Currently experiencing pain, swelling, pus, fever, or recent dental injury? □ No □ Yes
Describe symptoms, onset, and severity:_____

Dental history:

□ Gum disease/periodontal treatment
□ Frequent cavities
□ Root canal
□ Extractions
□ Dental implants
□ Braces/orthodontics
□ Dentures/partials
□ Night guard/retainer
□ Oral surgery
□ Dry mouth
□ Difficulty opening mouth
□ Dental anxiety/past difficult experience
□ Tobacco/vaping/nicotine use (optional)
□ Other: _____

Home oral-care routine:
Brushing: □ Less than daily □ Once daily □ Twice daily □ More than twice daily
Cleans between teeth: □ Daily □ Sometimes □ Never □ Not able
Products/devices used: _____

What makes oral care difficult? _____

Other oral-health concerns, comfort needs, or goals:

_____

_____

Patient/representative signature:_____ Date: _____

Caregiver & Communication Preferences

Optional authorization

Naming an emergency contact alone does not automatically authorize disclosure of health information. Identify people with whom Smiles at Home may communicate and topics permitted.
Name: _____ Relationship: _____
Phone/email: _____

May discuss:
- □ Scheduling
- □ Care instructions
- □ Health information needed to coordinate care
- □ Billing/payment
- □ Other: _____

Name: _____ Relationship: _____

Phone/email: _____

May discuss:
- □ Scheduling
- □ Care instructions
- □ Health information needed to coordinate care
- □ Billing/payment
- □ Other: _____

Preferences: □ Contact me directly first when practical
□ Contact person above if I cannot be reached
□ Do not leave detailed health information in messages

Special instructions: _____

This permission remains in effect until revoked in writing, unless an expiration is specified here:
_____

I understand I may revoke it in writing, subject to actions already taken in reliance on it and applicable law.
Patient signature: _____ Date: _____

Representative name/authority, if applicable: _____

Consent For Dental Hygiene Services

Please read before signing

I understand that Smiles at Home provides dental hygiene services within the scope of California law and the RDHAP's license, training, clinical judgment, and applicable authorization/consultation requirements. Services offered depend on my health history, oral findings, care setting, and what is legally permitted and clinically appropriate.

Before a service is performed, the RDHAP will explain the proposed service, expected benefits, material risks, reasonable alternatives, and relevant limitations. I may ask questions, decline a service, or withdraw consent at any time. Declining a service may affect the care that can be provided.

Dental hygiene services do not replace comprehensive dental care by a dentist. The RDHAP does not diagnose or treat conditions outside the RDHAP scope of practice. I may be advised or referred to a dentist, physician, or other health professional. Some concerns require prompt or emergency evaluation.

Possible discomfort or complications depend on the service and my individual health. Procedure-specific consent will be obtained when appropriate; this general consent does not replace it.

I have provided accurate medical and dental information to the best of my knowledge. I will report changes in my health, medications, allergies, or care team before treatment.

For care in a residence or facility, I understand that the treatment area may be adapted to the setting and care may be paused, modified, or deferred if the environment, patient condition, equipment, or safety conditions are unsuitable.

Patient name: _____

Patient signature: _____ Date: _____

Representative signature, if applicable: _____ Date: _____

Relationship/authority: _____

Staff use

□ Representative documentation reviewed (staff initials: _____)

: □ Services explained

□ Questions answered

□ Procedure-specific consent needed — document in chart

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Practices
Smiles at Home maintains paper patient charts and takes reasonable steps to protect your health information. We are required by law to protect its privacy, follow this notice, and notify affected individuals when a reportable breach occurs.

We may use your information to provide and coordinate care, obtain payment, and manage our practice. For example, we may document your treatment, communicate with another provider involved in your care, or maintain billing records. We may also disclose information when permitted or required by law, including certain public health, reporting, oversight, and legal proceedings.

Other uses or disclosures require your written authorization, which you may revoke in writing, subject to legal limitations. Information disclosed to others may no longer be protected by HIPAA.

We do not sell your health information or use it for unrelated marketing.

Your Rights
Subject to applicable law, you may request to inspect or obtain copies of your records, request corrections, ask for confidential communications or restrictions on certain disclosures, and request an accounting of certain disclosures. You may choose an authorized representative, receive a paper copy of this notice, and ask questions about our privacy practices. Contact us to exercise these rights.

Email and Text Messages
Ordinary email and text messages may not be secure and may be misdirected, intercepted, or viewed by others with access to your account or device. If you choose these methods, you acknowledge these potential risks. You may request another communication method. This choice does not authorize disclosure to unrelated parties.

Questions or Complaints
Contact Ilene Kendrick using the information above with questions or to file a complaint. You may also complain to the U.S. Department of Health and Human Services Office for Civil Rights at https://www.hhs.gov/hipaa/filing-a-complaint/index.html. We will not retaliate against you for filing a complaint.

We may revise this notice as permitted by law. The current notice is available upon request and at our website, if applicable.

Acknowledgment of Reciept

I acknowledge that I was offered or received a copy of the Smiles at Home Notice of Privacy Practices describing how my health information may be used and disclosed and how I may exercise my privacy rights.

Signing confirms receipt of the notice. It does not authorize uses or disclosures beyond those permitted by law or described in the notice.

Patient name: _____
Patient/representative signature: _____ Date: _____
Representative name and authority, if applicable: _____

If acknowledgment was not obtained:

- □ Patient declined to sign
- □ Unable to obtain acknowledgment
- □ Notice not provided due to emergency/other reason: _____

Staff name/initials: _____ Date: _____



Financial & Appointment Policies

As a portable dental hygiene practice, we operate as a fee-for-service provider and do not bill insurance directly. Services and fees will be discussed before care is provided. The patient or legally responsible party is responsible for payment, made by credit card, at the time of service- subject to applicable law and any written agreement.

Upon request, we are happy to provide you with a detailed receipt, including all applicable dental codes, which you can submit to your insurance provider for potential reimbursement. Coverage will vary based on your individual plan, especially for out-of-office services. Our goal is to make care accessible and convenient, while still supporting you in utilizing your insurance benefits whenever possible. Dental Claim forms for several major insurance companies can be found on our website for your convenience.

Cancellation/no-show policy and fee:
We understand that unexpected circumstances arise. Because appointments are reserved specifically for each patient and may require travel to the patient's home or residential facility, we ask for advance notice whenever an appointment needs to be changed. Please contact Smiles at Home by phone or by email as soon as possible if you need to make a change.

Appointments canceled with less than 48 hours' notice and missed appointments without notice may incur a fee of $75.

phone: (951) 584-3396
email: ilenek.RDHAP@gmail.com

If the patient is unavailable, not medically ready, or the setting is unsafe or unsuitable, care may be delayed, modified, or rescheduled. Any charge will follow the written policy provided in advance.

When the patient is unavailable or the visit cannot proceed
Please ensure the patient is available at the scheduled time and that the care environment is accessible and appropriate for treatment. If the patient is unavailable upon arrival, access cannot be obtained, or care cannot safely proceed, the appointment may need to be rescheduled. A fee may apply as described above.

Unexpected illness and emergencies
We understand that illness, hospitalization, emergencies, and circumstances beyond your control can arise. Please contact us as soon as possible. Fees may be waived at Smiles at Home's discretion when circumstances warrant.

If Smiles at Home must reschedule
If your appointment needs to be changed due to provider illness, an emergency, unsafe travel conditions, or other unforeseen circumstances, you will not be charged a cancellation fee by Smiles at Home.

Thank you for respecting our appointment schedule and helping us provide reliable, accessible dental hygiene care to our community.

I have read and understand these policies and any attached fee schedule.

Patient/financially responsible party: _____ Date: _____

Printed name and relationship, if not patient: _____

AGREEMENT TO ARBITRATE

This agreement concerns disputes alleging professional negligence in the provision of dental hygiene services. Please read it carefully before signing.

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature: _____ Date: _____

Printed Patient Name: _____ Date of Birth: _____

Representative Signature (if applicable): _____

Relationship/Authority: _____

Request/ Release of Dental Records

Only used when needed and with patient permission.

Patient name: _____ Date of birth: _____

□ Request records TO Smiles at Home FROM:

Provider/facility: _____

Address: _____ Phone: _____

□ Release records FROM Smiles at Home TO:

Provider/facility/person: _____

Address: _____ Phone: _____

Records:
□ Dental history/chart notes
□ Periodontal charting
□ Radiographs/images
□ Treatment plan
□ Medication/allergy information
□ Referral/consultation letters
□ Other: _____
Date range: _____

Purpose:
□ Treatment coordination
□ At patient's request
□ Other: _____

This authorization expires on: _____ or upon this event: _____.

I understand I may revoke this authorization in writing except to the extent action has already been taken in reliance on it. Information disclosed may be redisclosed by the recipient and may no longer be protected by certain privacy laws.

Patient/authorized representative signature: _____ Date: _____
Printed name and authority: _____

Minor or Representative Consent

Complete only when applicable

Patient name: _____ Date of birth: _____

I am signing on behalf of the patient as:

□ Parent of a minor
□ Legal guardian
□ Health-care agent
□ Other legally authorized representative:_____

Relationship to patient: _____

Basis of authority/documentation provided: _____

Phone: _____

I confirm that, to the best of my knowledge, the information provided is accurate. I understand Smiles at Home may request documentation of my authority to make healthcare decisions or receive information for the patient. Services may be deferred until authority is clarified when required.

Representative signature: _____ Date: _____

Printed name: _____

Intake Form: Clinical Use Only

Date received: _____ Packet reviewed by: _____

- □ Identity verified
- □ Medical history reviewed/clarified
- □ Medication list reviewed
- □ Allergies/reactions reviewed
- □ Emergency contact documented
- □ Representative authority checked, if applicable
- □ Notice of Privacy Practices provided
- □ Acknowledgment obtained or exception documented
- □ Consent for services signed
- □ Financial policy/fee schedule provided
- □ Applicable dentist/physician/collaborating-provider information documented
- □ Required consultation/authorization documented before applicable services
- □ Referral or urgent concern identified and addressed
- □ Dental history and oral assessment documented in clinical record
- □ Dental hygiene care plan documented
- □ Follow-up/referrals documented

Notes/outstanding items:

_____

_____

RDHAP signature/initials: _____ Date: _____