Welcome!

Thank you for selecting Royal Care Dentistry. We will strive to provide you with the best possible dental care. To help meet all of your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

How did you hear about us? □ Dentist □ Doctor □ Insurance □ Family/Friend _____

□ Yelp □ Google □ Social Media □ Other _____

PATIENT INFORMATION

Name:_____ Preferred Name:_____

Birthdate:_____ Sex: □ Female □ Male S.S.:_____

Home Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email: _____

Employer:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____ Phone:_____

INSURANCE INFORMATION

Do you currently have Dental Insurance? **□ Yes** **□ No**

If yes, Name of Insurance Company _____

Name of Policy Holder:_____ Birthdate:_____

Subscriber ID:_____ Group ID: _____

Do you have other Dental Benefits? **□ Yes** **□ No**

If yes, Name of Insurance Company _____

Name of Policy Holder:_____ Birthdate:_____

Subscriber ID:_____ Group ID: _____

MEDICAL HISTORY

Any History of:

Allergies	❑ YES	❑ NO	Emphysema	❑ YES	❑ NO	Hyperglycemia	❑ YES	❑ NO
Anemia	❑ YES	❑ NO	Epilepsy/Convulsions	❑ YES	❑ NO	Hypoglycemia	❑ YES	❑ NO
Arthritis	❑ YES	❑ NO	Epinephrine Sensitivity	❑ YES	❑ NO	Kidney or Liver Disease	❑ YES	❑ NO
Artificial Joints	❑ YES	❑ NO	Fainting or Dizzy Spells	❑ YES	❑ NO	Lung Disease	❑ YES	❑ NO
Asthma	❑ YES	❑ NO	Fever Blisters/Herpes	❑ YES	❑ NO	Nose Obstruction	❑ YES	❑ NO
Blood Transfusions	❑ YES	❑ NO	Glaucoma	❑ YES	❑ NO	Prolonged Bleeding	❑ YES	❑ NO
Bronchitis	❑ YES	❑ NO	Heart Murmur	❑ YES	❑ NO	Prostate Problems	❑ YES	❑ NO
Cancer	❑ YES	❑ NO	Heart Problems	❑ YES	❑ NO	Rheumatic Fever	❑ YES	❑ NO
Contact Lenses	❑ YES	❑ NO	Heart Valve Problems	❑ YES	❑ NO	Sinus Trouble	❑ YES	❑ NO
Cortisone or ACT	❑ YES	❑ NO	Hepatitis	❑ YES	❑ NO	Stroke	❑ YES	❑ NO
Diabetes	❑ YES	❑ NO	High Blood Pressure	❑ YES	❑ NO	Thyroid Problems	❑ YES	❑ NO
Emotional Stress	❑ YES	❑ NO	HIV	❑ YES	❑ NO	Ulcers	❑ YES	❑ NO

Do you have, or have you had, any diseases, conditions or problems not listed?
If yes, please specify:_____

Are you being treated by a physician now or have in the last six months? ❑ YES ❑ NO

Do you desire **ROUTINE DENTAL CARE**? ❑ YES ❑ NO
Primary Physician's Name: _____ Phone: _____
Address:_____
Street *City, State* *Zip Code*

Do you receive **Regular** medical "well checks"? ❑ YES ❑ NO
Date of Last Med. Exam: _____Reason for Last Med. Exam: _____
Are you taking any medications? ❑ YES ❑ NO (this includes over-the-counter and prescription drugs)
If yes, please specify:_____
Any recent serious illnesses? ❑ YES ❑ NO
If yes, please specify:_____

For women only:

Are you pregnant? ❑ YES ❑ NO
Are you nursing? ❑ YES ❑ NO
Are you on birth control? ❑ YES ❑ NO

Please indicate **allergies** or **reactions** to medications/latex/other: _____

Any other current illnesses or conditions:_____

_____

DENTAL HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? ❑ YES ❑ NO
2. Have you had any problems with previous dentistry? ❑ YES ❑ NO
3. Does Dental treatment make you nervous? ❑ YES ❑ NO
4. Have you ever been treated for any type of gum problems? ❑ YES ❑ NO
5. Are you happy with the appearance of your teeth? ❑ YES ❑ NO
   If no, what would you change? _____
6. How often do you brush?_____
   My home type of toothbrush is: ❑ Soft ❑ Medium ❑ Hard

Date of Last Dental Exam: _____ Reason:_____

Do you have, or have you ever had, any of the following?

Mouth Problems:			**Teeth Problems:**		
Bleeding/sore gums	❑ YES	❑ NO	Loose teeth	❑ YES	❑ NO
Unpleasant taste/bad breath	❑ YES	❑ NO	Sensitive to hot	❑ YES	❑ NO
Burning tongue/lips	❑ YES	❑ NO	Sensitive to cold	❑ YES	❑ NO
Frequent blisters/lips/mouth	❑ YES	❑ NO	Sensitive to sweets	❑ YES	❑ NO
Swelling/lumps in mouth	❑ YES	❑ NO	Sensitive to biting	❑ YES	❑ NO
Ortho treatment (braces)	❑ YES	❑ NO	Food stuck in teeth	❑ YES	❑ NO
Biting cheeks/lips	❑ YES	❑ NO	Clenching/grinding	❑ YES	❑ NO
Clicking/popping jaw	❑ YES	❑ NO	If so, when_____		
Difficulty opening/closing jaw	❑ YES	❑ NO	Shifting in bite	❑ YES	❑ NO
Headaches	❑ YES	❑ NO	Change in bite	❑ YES	❑ NO
Do you use the following:					
Brush	❑ YES	❑ NO	Dental floss	❑ YES	❑ NO
Fluoride Rinse	❑ YES	❑ NO	Other_____		

How would you rate your dental health? ❑ Excellent ❑ Good ❑ Poor
Any concerns or questions you have?_____
_____

These are things that are important to me about my dental health:_____
_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes to my medical status. I understand that providing incorrect information can be dangerous to my health.

Patient Signature _____ Date _____
(Parent/Guardian)

PATIENT TREATMENT AND FINANCIAL POLICY

Thank you for choosing Royal Care Dentistry as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Payment is due at the time service is provided unless another arrangement is made. Booking a longer appointment time or specialized treatment may require pre-payment ahead of the appointment. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. Outside financing is available upon request and approval. Please note: Additional fees will be applied for returned checks. All account balances over 90 days may be subject to a late fee.

As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid.

All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you,our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. In the event Royal Care Dentistry seeks enforcement of this agreement through the services of our collection agency, Valley Credit Services, the patient/guardian shall be responsible for any expenses including collection costs.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Missed Appointment(s) and Cancellations: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 48 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Communications with you: By signing below, you are authorizing us to contact you at any telephone number and/or email address you provide for any lawful purpose.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given the right to review such Notice of Privacy Practice prior to signing this consent. I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient Signature_____ **Date**_____
(Parent/Guardian)
Print Name _____