Royal Dental

PATIENT INFORMATION :

Date _____

Name_____

Birthdate_____

SS#_____

Address_____

City_____ State _____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Check Box Minor Single, Married/ Male, Female

Person to contact in case of emergency: _____

Phone _____

Email _____

RESPONSIBLE PARTY:

Name of Person Responsible for this Account_____

Relationship to patient_____

Address (If different from patient) _____City_____ State____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone _____

SS#_____ Driver's License #_____ Birthdate_____

Employer_____

Email_____

INSURANCE INFORMATION:

Name of Insured_____ Birthdate_____

SS#_____ Relationship to Patient_____

Name and Address of Employer_____

Insurance Company_____ Policy/Member ID#_____

Group#_____ Ins Co Address_____ City_____ State_____ Zip_____

Do you have additional dental insurance? Yes/ No If YES, please complete the following:

Name of Insured_____ Birthdate_____

SS#_____ Relationship to Patient_____

Name and Address of Employer_____

Insurance Company_____ Policy/Member ID#_____

Group#_____ Ins Co Address_____ City_____ State_____ Zip_____

To accommodate all of our patients, we are implementing a "cancellation/no show" policy effective immediately. If you do not give 24 hours' notice for cancellations, you may be charged a cancellation fee and your appointment may be cancelled. As a courtesy, we give reminder calls and emails. To hold your appointment, we will need to hear back from you, whether via phone call or email.

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PATIENT INFORMATION

Patient Name: _____ Today's Date: _____
Last First MI

Birth Date: _____

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for Today's Visit: _____

Have you ever had any of the following? Check ☑ those that apply:

☐ADHD	☐Diabetes	☐High Blood Pressure	☐Sickle Cell Anemia
☐Allergies: _____	☐Dizziness	☐HIV/AIDS	☐Sinus Problems
_____	☐Drug/Alcohol Addiction	☐Jaundice	☐Smoker / Tobacco User
☐Anemia	☐Emphysema	☐Kidney Disease	☐Stomach Problems
☐Anxiety	☐Epilepsy	☐Liver Disease	☐Stroke
☐Arthritis	☐Excessive Bleeding	☐Mental Disorders	☐Thyroid Problems
☐Artificial Joints	☐Fainting	☐Nervous Disorders	☐Tuberculosis
☐Asthma	☐Glaucoma	☐Pacemaker	☐Tumors
☐Autism	☐Growths	☐Penicillin Allergy	☐Ulcers
☐Blood Disease	☐Hay Fever	☐*Currently* Pregnant:	☐Venereal Disease
☐Blood Transfusion	☐Headaches	*Due Date:* _____	☐Other: _____
☐Cancer	☐Head Injuries	☐Radiation Treatment	_____
☐Cholesterol (high)	☐Heart Disease	☐Respiratory Problems	
☐Codeine Allergy	☐Heart Murmur	☐Rheumatism	
☐Depression	☐Hepatitis A, B or C	☐Shortness of Breath	

Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

Are you currently having any dental pain or problems? Yes No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

Are you now under the care of a physician? Yes No
If yes, please explain: _____
Name of Physician: _____

Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

Are you currently taking any medications, pills or drugs? Yes No
If yes, list medications: _____

Are you allergic to or have you ever experienced any ill effect from a local anesthetic or any drugs? Yes No
If yes, describe (i.e., rash, itching, difficulty breathing, etc.): _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian: _____ Date: _____

Doctor's Signature: _____ Date: _____

Royal Dental Financial Agreement

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as a comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. Unless we receive notice of cancellation 24 hours in advance, **you will be charged $35.00**. Please help us service you better by keeping scheduled appointments.

INSURANCE: Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.** If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware that some or perhaps all of the services provided may or may not be covered by your insurance policy. **Any balance is your responsibility whether or not your insurance company pays any portion.**

PAYMENT:

FULL PAYMENT is due at the time of service with or without insurance. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES** are due at the time of service, unless other arrangements are made.

FINANCIAL AGREEMENT:

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, Visa, American Express, Mastercard and/or Discover. We also offer **CARECREDIT**, which is a financing option that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance. After 90 days of non-payment patient accounts will be sent to the collection agency for payment.

If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees and court costs associated with the recovery of the monies due on the account.

I have read, understand and agree to the terms and conditions of this financial agreement.

Signature: _____

Date: _____

Royal Dental

Information Release:

Acknowledge of receipt of notice of privacy practices, Authorization to release information and authorization of payment benefits. I've received a copy of Royal Dental's notice of privacy. practices. I hereby authorize Royal Dental to provide any insurance company(s), claim administrator(s) and consulting healthcare professional(s), information concerning health care, payment, treatment, or supplies provided. This information will be used exclusively for the purpose of attaining and administering claims for benefits. I further authorize payment directly to Royal Dental. I agree that a photocopy of this authorization is a valid as the original.

Patient Agreement:

I understand and agree that payment is due at the time services are rendered and that health, dental accident, insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary dental reports and dental forms to assist me in any collection from my insurance company and that any amount authorized to be paid directly to the office will be credited to my account to me on receipt. However, I clearly understand and agree that all services rendered to me will be charged directly to me and that I am personally responsible for my account, regardless of insurance. In the event my account balance is referred to any agency or agencies for collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. In the event that the patient is a minor, I am the patient and/or guardian of said patient and agree that I am responsible for all services rendered to the patient herein. I understand that if I suspend or terminate any care and treatment to any person referred in to the previous sentence, any fees, for professional services, including interrupted service fees if applicable, will be immediately due and payable.

(If patient is a minor, Parent or guardian must sign)

Signature:_____ Date:_____

Royal Dental

Cancellation, No- Show, Missed appointment policy:

Here at Royal Dental our office hours are by appointment ONLY and we do value your time. This office is a general dental office and is not a dental clinic. Your appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please make sure that you are able to keep it as our policy is listed below. This office does call, and e-mail to confirm your appointments; So please make sure we have a good e-mail and phone number on file. Please make a note of any dental appointments we have scheduled, in a place where you will be easily reminded. If you cannot make your appointment, please notify the office within 48 hours to cancel or make changes to your appointment.

We enforce the three (3) broken appointment policy meaning that after three broken appointments we will no longer schedule that patient, any adult/child living in the same residence, or any adult responsible for a child's dental treatment for three (3) months from the date of the third broken appointment. After that if you do not show up you will be dismissed from the practice.

As a courtesy, we do see patients on Saturdays and If you schedule a Saturday appointment and do not show we will not schedule you for another Saturday appointment.

NO EXCEPTIONS.

It is the responsibility of the patient (or parent/guardian, in case of a child) to notify us any time they will not available for their reserved appointment. However, without confirmation from you, we will remove your appointment from the schedule and consider it a broken appointment if are unable to reach you.

If you have any questions regarding our appointment cancellation policy, please feel free to ask the front desk staff. Thank you for your cooperation.

Signature of parent/Legal Guardian:_____

Date:_____

Royal Dental

Office policy for accompanying children in the operatory:

We would like to continue offering the parent/guardian of our patients the privilege of accompanying their child/children to our child friendly operatory during their dental visit. To continue this offer we need the parent/guardian to follow these procedures.

1.) For the doctor and the staff to focus on your child's needs during their scheduled treatment with our office, it is necessary to ask that only ONE adult accompany your child/children eight (8) years and younger to the clinical area. This request will help with the doctor's ability to discuss any questions or concerns you may have during this time.

2.) All siblings of patients not scheduled to be seen by the doctor MUST remain in the waiting room with an accompanied adult. Siblings may NOT be left in the waiting room without adult supervision.

3.) Only during exceptional circumstances, May ONE parent/guardian may be allowed to stay in the operatory with the patient. Please notify the front desk prior to being called back for your visit.

4.) Please take a moment to review each of these policies and procedures and ask our staff for further explanations of any questions you may have.

Thank you for your cooperation

Signature of parent/guardian:_____

Date:_____

Royal Dental

Authorization for a Guardian Representative of a Minor

The undersigned, who is the biological parent or legal guardian of the minor

_____, hereby agrees, relinquishes, and assign

Name of Minor

_____all responsibilities, obligations, decisions, and other

Parent / Guardian Representative

parental duties, exclusive of any and all financial obligations occurring therefrom, for the sustenance, maintenance, support and other custodial duties for the said minor. This agreement is established under the condition of in loco parentis (in the place of a parent) for the signatory parties. I understand that if I am the parent of a minor (under the age of 18) that is receiving treatment in the dental office. I will remain in the waiting area unless asked to come to the treatment operatory by the doctor and/or staff.

Parent / Legal Guardian must complete this form and sign:

_____ _____

Signature of Parent/guardian Date