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 ☐ Family ☐ Friend ☐ Doctor ☐ Community Event ☐ Website
☐ Internet ☐ Yellow Pages ☐ Valpak ☐ Other_____

Name of person to thank for referring you?_____

PATIENT INFORMATION

Name:_____ Preferred Name:_____
Birthdate:_____ Age:_____ Sex: ☐ Male ☐ Female S.S. #:_____
Home Address:_____
Street *City, State* *Zip Code*
Home Phone:_____ Cell Phone:_____ E-mail:_____
Employer:_____ Work Phone:_____
Employer's Address:_____
Street *City, State* *Zip Code*
If patient is a full time student, Name of school:_____

Do you or any family members have an account with Royal Care Dentistry, LLC? ☐ **Yes** ☐ **No**
If so, list name(s)_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____ Phone:_____

CONSENT FOR DENTAL TREATMENT

I request and authorize the doctors employed at Royal Care Dentistry, LLC to examine, clean, and provide dental treatment on my teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the doctors to diagnose and/or treat my dental problem. I will allow photographs to be taken of my teeth for diagnostic or educational purposes. I will be responsible for any charges incurred on this child for dental treatment.

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

INSURANCE INFORMATION

Does your employer offer Dental Benefits? ☐ **Yes** ☐ **No**

If yes, Name of Insurance Company _____

Name of Insurance Company _____

Group #_____ Plan #_____ Insurance Phone #_____

Insurance Address:_____

Street *City, State* *Zip Code*

Are you covered under any other insurance? ☐ **Yes** ☐ **No**

If yes, name of insured_____ Birthdate_____ S.S.#_____

Relationship to patient_____

Name of Insurance Company _____

Group #_____ Plan #_____ Insurance Phone #_____

Insurance Address:_____

Street *City, State* *Zip Code*

AUTHORIZATION AND RELEASE

All of the questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such dental care to third party payers and/or health practitioners. I authorize and release my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand I am required to take care of any portion not expected to be paid by insurance at the time of treatment. If the dental insurance carrier pays less than expected, I understand any remaining balance is my responsibility and I agree to be responsible for payment of all services rendered. I understand that I am responsible for all fees for services rendered. In the event Royal Care Dentistry, LLC seeks enforcement of this agreement through the services of a collection agency, I shall be responsible for any incidental expenses, including collection costs and reasonable attorney's fees.

Patient (Parent/Guardian) Signature_____ Date_____

Print Name_____

MEDICAL HISTORY

Name:_____ Preferred Name:_____

Any History of:

Allergies	❑ YES	❑ NO	Emphysema	❑ YES	❑ NO	Hypoglycemia	❑ YES	❑ NO
Anemia	❑ YES	❑ NO	Epilepsy/Convulsions	❑ YES	❑ NO	Kidney or Liver Disease	❑ YES	❑ NO
Arthritis	❑ YES	❑ NO	Epinephrine Sensitivity	❑ YES	❑ NO	Lung Disease	❑ YES	❑ NO
Artificial Joints	❑ YES	❑ NO	Fainting or Dizzy Spells	❑ YES	❑ NO	Nose Obstruction	❑ YES	❑ NO
Asthma	❑ YES	❑ NO	Fever Blisters/Herpes	❑ YES	❑ NO	Prolonged Bleeding	❑ YES	❑ NO
Blood Transfusions	❑ YES	❑ NO	Glaucoma	❑ YES	❑ NO	Prostate Problems	❑ YES	❑ NO
Bronchitis	❑ YES	❑ NO	Heart Murmur	❑ YES	❑ NO	Rheumatic Fever	❑ YES	❑ NO
Cancer	❑ YES	❑ NO	Heart Problems	❑ YES	❑ NO	Sinus Trouble	❑ YES	❑ NO
Contact Lenses	❑ YES	❑ NO	Heart Valve Problems	❑ YES	❑ NO	Stroke	❑ YES	❑ NO
Cortisone or ACT	❑ YES	❑ NO	Hepatitis	❑ YES	❑ NO	HIV Positive	❑ YES	❑ NO
Diabetes	❑ YES	❑ NO	High Blood Pressure	❑ YES	❑ NO	Thyroid Problems	❑ YES	❑ NO
Emotional Stress	❑ YES	❑ NO	Hyperglycemia	❑ 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:_____ Do you have allergies or reactions to any medications or latex? ❑ YES ❑ NO
If yes, please specify:_____
Any recent serious illnesses? ❑ YES ❑ NO
If yes, please specify:_____
For women only:

Are you pregnant? ❑ YES ❑ NO If yes, what month?_____
Are you nursing? ❑ YES ❑ NO
Are you on birth control? ❑ YES ❑ NO

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

Please list name and amount of **ANY** prescription medications/vitamins/supplements taken:

_____

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 ever had any problems associated with previous dentistry?..... ❑ YES ❑ NO
3. Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely
4. Date of your last dental visit? _____
5. Have you ever been treated for any type of gum problems? .....
6. How often do you brush?_____ Brush is: ❑ Soft ❑ Medium ❑ Hard

7. Are you happy with the appearance of your teeth? ❑ YES ❑ NO
   If no, what would you change?_____

8. 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 or closing jaw	❑ YES ❑ NO	Shifting in bite	❑ YES ❑ NO
Headaches	❑ YES ❑ NO	Change in bite	❑ YES ❑ NO

9. Do you use the following?

Brush	❑ YES ❑ NO	Dental floss	❑ YES ❑ NO
Fluoride Rinse	❑ YES ❑ NO	Other_____	

10. How would you rate your dental health? ❑ Excellent ❑ Good ❑ Poor
11. 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 that 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 (Parent/Guardian) Signature_____ Date_____

Print Name_____