ROYAL CARE DENTISTRY
For every member of your Family

Welcome!

Thank you for selecting Royal Care Dentistry, LLC .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 ☐ Pediatrician ☐ Community Event ☐ Website

☐ Internet ☐ Yellow Pages ☐ Val Pak Other_____

Name of person to thank for referring your child?_____

CHILD'S INFORMATION

Child's Full Name:_____ _____

Birthdate:_____ Age:_____ Grade:_____ Sex: Male ☐ Female S.S. #:_____

School:_____ Names & ages of siblings:_____

PARENT'S INFORMATION

Who has legal custody of patient?_____

Child lives with: ☐ Mother ☐ Father ☐ Guardian ☐ Other:_____

Name of person responsible for this account: _____
Father/Guardian:_____ Birthdate:_____ S.S. #:_____
Home Address:_____
Street *City, State* *Zip Code*
Phone: Home _____ Cell_____ Work_____ E-mail:_____
Father/Guardian's Employer:_____
Employer's Address:_____
Street *City, State* *Zip Code*
Mother/Guardian:_____ Birthdate:_____ S.S. #:_____
Home Address: (if different)_____
Street *City, State* *Zip Code*
Phone: Home _____ Cell_____ Work_____ E-mail:_____
Mother/Guardian's Employer:_____
Employer's Address:_____
Street *City, State* *Zip Code*

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 child's 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 child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The doctors and staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Parent/Guardian Signature_____ Date_____

INSURANCE INFORMATION

Does Father's (Guardian's) Employer offer Dental Benefits? ☐ **Yes** ☐ **No**

If yes, Name of Insurance Company _____

Group #_____ Plan #_____ Insurance Phone #_____

Insurance Address:_____

Street *City, State* *Zip Code*

Does Mother's (Guardian's) Employer offer Dental Benefits? ☐ **Yes** ☐ **No**

If yes, Name of Insurance Company _____

Group #_____ Plan #_____ Insurance Phone #_____

Insurance Address:_____

Street *City, State* *Zip Code*

Is child 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 to my child 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 to my child. 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.

Parent/Guardian Signature_____ Date_____

Print Name_____

MEDICAL HISTORY

Do you desire **ROUTINE DENTAL CARE** for your child? ☐ **Yes** ☐ **No**

Primary Physician's Name: _____ Phone: _____

Address:_____
Street *City, State* *Zip Code*

Does your child receive **Regular** medical "well checks"? ☐ **Yes** ☐ **No**

Date of Last Med. Exam: _____Reason for Last Med. Exam: _____

Are immunizations current? ☐ **Yes** ☐ **No** If not, please note reason:_____

Was birth full-term or premature (number of weeks)? _____

Has Mother or child had a history of illness at birth or after? (Ex. Frequent infant ear infections, complicated

Delivery, frequent use of antibiotics, etc.) ☐ **Yes** ☐ **No** If yes, explain_____

Please check Yes or No if your child is, or has been, affected by any of the following conditions:

Physical Disability	**Yes**	**No**	Previous Hospital Admission(S)	**Yes**	**No**
Seizures/Epilepsy	**Yes**	**No**	Asthma	**Yes**	**No**
Tuberculosis	**Yes**	**No**	Rheumatic Fever	**Yes**	**No**
HIV/AIDS	**Yes**	**No**	Congenital Heart Defect/Heart Conditions	**Yes**	**No**
Diabetes	**Yes**	**No**	Congenital Birth Defect	**Yes**	**No**
Hepatitis	**Yes**	**No**	Abnormal Blood Pressure	**Yes**	**No**
Cancer	**Yes**	**No**	Bleeding Disorder	**Yes**	**No**
Kidney/Liver Problems	**Yes**	**No**	Hearing Impairment	**Yes**	**No**
Psychiatric Therapy	**Yes**	**No**	Learning Disability	**Yes**	**No**
ADD/ADHD	**Yes**	**No**	Autism	**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/concerns not listed above:

_____

DENTAL HISTORY

Is this your child's first visit to a Pediatric Dental Office? ☐ **Yes** ☐ **No**

If NO, please indicate previous name and location: _____

Please describe previous dental experience (if any):_____ How

Did your child react at previous office? _____

What was your (parent/guardian) reaction at previous office? _____
Name of previous dentist: _____
Date of last visit: _____ Date of last x-rays: _____
At what age/month did your child's first tooth arrive? _____

Does your child brush daily? **Yes** **No** How Often (times per day) _____
Do you assist your child in brushing? **Yes** **No** How Often_____
Do you floss your child's teeth? **Yes** **No** How Often_____
Does your child take fluoride or vitamin supplement? **Yes** **No** How Often_____
Does your child have any mouth habits? **Yes** **No** Describe_____
(thumb sucking, pacifier use, nail biting, chewing pencils, etc.) _____
Does your child take a bottle or sippy cup to bed? **Yes** **No** If yes, what contents? _____
Does your child have a history of cold sores/fever blisters? **Yes** **No**
Describe_____

Has your child complained or shown symptoms of dental problems (pain, fingers in mouth, etc.)? Yes No How recently_____
Describe _____
Main dental concerns: _____

Has your child had any bad dental experiences? Yes No
Describe_____

_____

Has your child had any injuries to the mouth or head? Yes No
Describe_____

_____

DIETARY HISTORY

Does your child snack frequently? Yes No On what? _____
Does your child drink juice frequently? Yes No what kind? _____
Note: Many fruit juices have natural acids which can cause cavities if taken frequently
Does/did your child take a bottle to bed? Yes No Explain: _____
Is your home water supply fluoridated? Yes No
Does your child take a fluoride supplement? Yes No

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 child's medical status. I understand that providing incorrect information can be dangerous to my child's health.

Parent/Guardian Signature_____ Date_____
Print Name_____