Royal Dental

DATE ____ / ____ / ____

Patient Information

Name _____ Preferred Name _____
(Last) (First) (Middle)

DOB _____ Sex: ☐ M ☐ F Status: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

SS# _____

Spouse Name _____ Children: ☐ Y ☐ N How Many: _____ Ages: _____

MAILING ADDRESS

Street _____ Apt _____ Home _____

City _____ State _____ ZIP _____ Work _____

E-mail _____ Cell _____

EMPLOYMENT

Employer _____ Occupation _____

Employer Address _____

HOW DID YOU HEAR ABOUT US? _____

Insurance Information (if applicable)

PRIMARY DENTAL INSURANCE

Company Name _____ Phone _____

Address _____ Insured ID# _____

Insurance Group# _____ Plan/Local/Policy# _____

Insured Name _____ Relation _____

Insured DOB _____ Insured Employer _____

SECONDARY DENTAL INSURANCE

Company Name _____ Phone _____

Address _____ Insured ID# _____

Insurance Group# _____ Plan/Local/Policy# _____

Insured Name _____ Relation _____

Insured DOB _____ Insured Employer _____

PATIENT'S NAME _____
E-MAIL ADDRESS_____
CELL PHONE # _____

Your Medical History

CURRENT MEDICATION LIST

Yes	No		Yes	No		Yes	No	
○	○	None	○	○	Nerve Pills	○	○	Pain Medication
○	○	Insulin	○	○	Fen-Phen/Redux	○	○	Muscle Relaxers
○	○	Stimulants	○	○	Blood Thinners	○	○	Tranquilizers
○	○	Steroids	○	○	Bisphosphonates (e.g. Fosamax/Aredia for Osteoporosis)			

MEDICATION (S)_____

_____

MEDICAL CONDITIONS, PROCEDURES OR DISEASE

Yes	No		Yes	No		Yes	No	
○	○	Artificial Joints/Bones	○	○	Asthma	○	○	Anemia
○	○	Arthritis/Rheumatism	○	○	Artificial Valves	○	○	Chest Pains
○	○	Back Problems	○	○	Bleeding Problems	○	○	Cancer/Tumors
○	○	Congenital Heart Defect	○	○	Thyroid Problems	○	○	Radiation/Chemotherapy
○	○	Diabetes / Hypoglycemia	○	○	Heart Disease	○	○	Fainting/Seizures/Epilepsy
○	○	Kidney Problems	○	○	Liver Problems	○	○	Heart Attack
○	○	High Blood Pressure	○	○	Heart Murmur	○	○	Heart Surgery/Pacemaker/Stints
○	○	HIV/AIDS	○	○	Jaw Pain TMJ / TMD	○	○	Sinus Problems
○	○	Mitral Valve Prolapse	○	○	Nervousness	○	○	Leukemia
○	○	Rheumatic/Scarlet Fever	○	○	Transplants	○	○	Tuberculosis/ TB
○	○	Stomach Problems/Ulcers	○	○	Venereal Disease	○	○	Psychiatric Problems
○	○	Hepatitis _____	○	○	Alcohol/Drug Abuse	○	○	Cosmetic Surgery _____
○	○	Intellectual & developmental disabilities				○	○	Respiratory Problem (Emphysema, COPD)

OTHER CONDITIONS OR SURGERIES WITH DATES

_____

_____

ALLERGIES

○ None ○ Penicillin/Amoxicillin ○ Tetracycline ○ Aspirin

○ Dental Anesthetic ○ Foods _____ ○ Latex ○ Other _____

FOR WOMEN

Birth Control: ○Y ○ N Pregnant: ○Y ○ N Nursing: ○Y ○ N # of children _____

_____ _____

PATIENTS SIGNATURE DATE CLINICIAN SIGNATURE

PATIENT'S NAME _____ DATE ____ / ____ / ____

Patient Account Authorization

PERSON ULTIMATELY RESPONSIBLE FOR THE ACCOUNT

Name _____ SS# _____

Relation _____

Billing Address (mark box if same as personal address) ☐

City _____ State _____ ZIP _____

Street _____ APT _____

Drivers License# _____ Phone _____

PAYMENT METHOD

☐ Cash ☐ Check ☐ Credit Card CC# _____ Exp Date _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Authorize with Initials _____

In Case of Emergency

Whom should we contact? _____

Relation _____

Phone 2 _____ Phone 1 _____

☐ Cell ☐ Work ☐ Home ☐ Cell ☐ Work ☐ Home

Practice Understanding and Agreement

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with _____ the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature

_____ Date _____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

NOTICE OF PRIVACY PRACTICES

Review Carefully

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or with the Department of Health & Human Services- Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Who may we give information to regarding your condition, treatment, or diagnosis?

Name: _____ Phone #: _____

By my signature below, I acknowledge that I have read the Notice of Privacy Practices

Patient Signature: _____ Date: _____

FOR MORE INFORMATION ABOUT HIPPAA CONTACT: (202) 619-0257
THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES WWW.HHS.GOV