Royal Dental *Spa*

Thank you for selecting our office as your dental healthcare team! We strive to provide you with the best possible dental care. To help us meet all your dental 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!

Patient Information (CONFIDENTAL) Today's Date:_____

NAME: _____ Birthdate:___/____/_____ Home Phone: (__)_____

Address: _____ City: _____ State/Zip: _____

Email:_____ Cell Phone: (___) _____ Soc. Sec. #: _____

Check Appropriate Box☐ Minor ☐ Married ☐ Divorced☐ Widowed ☐ Separated

Patient's Employer:_____ Work Phone: (___)_____

Business Address :_____ City: _____ State/Zip:_____

Spouse or Parent/Guardian's Name: _____ Work Phone (___) _____

Spouse or Parent/Guardian's Employer: _____

Whom May We Thank for Referring You?_____

Person to Contact in Case of Emergency: _____Phone: (___) _____

Responsible Party

Name of Person Responsible for this Account: _____Relationship to patient:_____

Employer: _____Work Phone: (__) _____

Is this person currently a patient in our office? ☐Yes ☐No Are there other family Members? ☐Yes☐No

For your convenience, we offer the following methods of payment. Please check the option you prefer:

☐Cash ☐ Personal Check **Credit Card**: ☐ Visa ☐MasterCard ☐Care Credit

Insurance Information

Name of Policy Holder: _____ Relationship to Patient:_____

Policy Holder Birthdate: _____/_____/_____ SSN#:_____

Name of Employer:_____ Work Phone: (___) _____

Insurance Company: _____Group # _____ Policy ID: _____

Do You Have Additional Insurance? ☐ Yes ☐ No IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Policy Holder: _____ Relation to Patient:_____

Policy Holder Birthdate: _____/_____/_____ SSN#:_____

Name of Employer:_____ Work Phone: (___) _____

Insurance Company: _____Group # _____ Policy ID: _____

Royal Dental Spa

Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed	◯ Yes ◯ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Royal Dental *Spa*

Our goal is to provide you and your family with optimal dental care. WE want you to feel welcome and as 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.

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, check, Visa, MasterCard and/or Discover. We also offer Care Credit with 6, 12, & 18 month no interest, which is a financing option available only for healthcare expenses.

Optional payment terms:

1. ***Full pay cash discount****: We offer a 5% accounting courtesy for all services over $500 that is paid in full prior to the commencement of services.*
2. *Term Loan: By arrangements with Care Credit we can offer patients upon approval, an interest-free term loan (up to 18 months) with no down payment, no annual fee and no prepayment penalty. Ask for an application today.*

*There will be a fee for any additional procedure **NOT** included in the original treatment plan.*

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. We require at least a 24 hour notice for any cancelled appointment. We reserve the right to charge a **$30.00** fee for any appointment that was missed or cancelled without the minimum of 24 hours' notice.*

SERVICE CHARGES:

We will charge a 1.5% monthly, 18% annual percentage billing charge that will be applied to all accounts over 90 days past due. We will charge a $50.00 fee for all returned checks. Any fee incurred to collect payment from a professional agency will be billed to and payable by the patient or patient's responsible party.

INSURANCE INFORMATION:

As a courtesy to our insured patients, we will submit claims to your insurance company free of charge. We will help receive your maximum allowable benefits. In order to do this, we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January to December).

Our doctor will diagnose treatment based on your dental health not your insurance coverage.

You must realize that:

Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for a tooth that has extensive decay, however, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to our office and be reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. The insured has a better ability to deal with the insurance company and the employer responsible for the policy.

Know Your Rights

Your decision to sign this Authorization is voluntary. Royal Dental Spa will not refuse treatment to you if you refuse to sign this Authorization.

When your protected health information is released as provided by this Authorization, please be aware that the named recipient (above) may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

Patient Signature

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting Royal Dental Spa to release, use or disclose my protected health information.

Signature	Date
Print Name	Witness (Optional)

Representative Signature

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use or disclosure the patient's protected health information.

Signature	Date
Print Name	Relationship to Patient

☐ Parent ☐ Guardian ☐ Power of Attorney

FOR OFFICE USE ONLY

Date Received	By	Patient ID

-ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Royal Dental Spa

24 East Crossville Rd. Ste 140

Roswell, GA 30075

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Royal Dental Spa's *HIPAA Notice of Privacy Practices*.

I understand that's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Royal Dental Spa's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Royal Dental Spa's *HIPAA Notice of Privacy Practices*, I may contact Diane Lett-Walker (678)878-2801.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Royal Dental Spa will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Royal Dental Spa's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask [Diane Lett-Walker], noted above, for assistance.

_____ Patient Signature

_____ Date

_____ Signature of Personal Representative

_____ Print Name of Personal Representative

_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Royal Dental Spa made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Royal Dental Spa was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____
