ROYCE
FAMILY DENTISTRY

Patient Medication List

Patient Name	Date of Birth:	Male or Female:
Allergies/ Adverse reactions to Medication:	Pharmacy Name:	Pharmacy Number:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: gingseng, gingko). Include medications taken as needed (example: nitroglycerin).

Name of Medicine (brand or generic)	**Dose** (mg, puffs, drops)	**Schedule** (times per day)

ROYCE
FAMILY DENTISTRY

Patient Name: _____ Birth Date: _____ Date Created: _____

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, Ac!Dnel or any other mecications containing bisphosphonates?	☐ yes ☐no	if yes
Do you use tobacco?	☐ yes ☐no	if yes
Are you on a special diet?	☐ yes ☐no	if yes
Do you use controlled substances?		if yes

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other?
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics if yes _____

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

AIDS/HIV Positive ☐Yes ☐No	Cortisone ☐Yes ☐No	Hemophilia ☐Yes ☐No	Radiation Treatments ☐Yes ☐No
Alzheimer's Disease ☐Yes ☐No	Medicine 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
Arttvitis/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 Easly ☐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 Usted above? ☐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 responsibitity to inform the dental office of any changes in medical status. Signature of Patient, Parent or Guardian:

Signature: _____ Date: _____

ROYCE
FAMILY DENTISTRY

Thank you for choosing Royce Family Dentistry as your dental provider! To help us meet your entire dental healthcare needs, please fill out these forms completely. If you need any assistance or have any questions, please ask and we'll be happy to help! We also give out gift cards for referrals that have treatments.

Referrals are important to us! Please tell us how you heard about us:

☐ Google ☐ Direct Mailer ☐ Insurance ☐ Facebook ☐ Twitter ☐ Other _____

If referred by a patient/relative, whom may we thank for referring you: _____

How do you prefer to be contacted? ☐ Cell phone ☐ Home phone ☐ Email ☐ Other _____

Patient Information

Name: _____ Preferred Name: _____ Sex: M F

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Patient SSN: _____ Date of Birth: _____ Work Phone: _____

Email: _____

Check appropriate box: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient or Parent/Guardian Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Responsible Party Information

Person responsible for account: _____ Date of Birth: _____

SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ Relationship to Patient: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ DOB: _____

Insurance Company: _____ Name of Employer: _____

Policy/ID Number: _____ Group Number: _____ Insurance Phone Number: _____

Patient/Responsible Party Signature: _____ Date: _____

ROYCE
FAMILY DENTISTRY

FINANCIAL AGREEMENT AND OFFICE POLICIES

In order to keep our fees as low as possible we have implemented the following policies. Please read the following information *carefully* to minimize billing and insurance problems.

Payment: Payment is due in full for each appointment as services are rendered. The payment options are:

- **Cash**
- **Credit Card**
- **Money Order**
- **Check - if paying by check, there will be a $25 returned check fee assessed to your account on all returned checks.**

In instances where the service to be provided is above $250, the patient will be asked to pay a non-refundable deposit of $100 to secure an appointment slot. If the patient does not cancel the appointment within 36 hours, the patient will lose this deposit.

Dental Insurance: Dental insurance is a contract between you and your insurance company. All charges you incur are your responsibility regardless of your insurance coverage.
There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not party to this contract. We have no control over the terms of your contract or the determination of your benefits. We will file your primary dental insurance claims as a courtesy to you. We do NOT guarantee payment and are not responsible for providing you with the plan limitations, exclusions and provisions determined by your insurance company. You agree to pay any portion of the charges not covered by your insurance. We will file a pre-determination for recommended treatment when it is requested by you.

Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

_____ I understand that **if the patient does not have dental insurance**, payment in full is expected on the day of service.

_____ I understand that if the patient does have dental insurance, the responsible party will pay the patient estimated portion and deductible on the day of service: the insurance will be billed as a courtesy; however, I am aware, if the insurance does not pay within 60 days payment in full is expected from the responsible party. I understand it is my responsibility to know and understand my benefits, and the fees quoted in our office are only estimates. I am responsible for anything that my insurance does not cover. I understand that if my insurance company has not paid the balance in full within 60 days, the balance will automatically be transferred to my account and I will be responsible for the balance owed. Our office does not render services on the assumption that your treatment will be paid by your insurance company.

ROYCE
FAMILY DENTISTRY

Emergency Appointments: All emergency dental appointments must pay for the exam and x-ray when checking in. Any additional treatment or any dental services performed must be paid for in full at the time of service.
Upon examination, your doctor will prepare a treatment plan. The treatment plan is only an estimate of the dental care required and should not be construed as a statement of actual charges. A plan may need updating after treatment has started as each procedure is unique.

Missed Appointments: A missed appointment is defined as a cancellation, no-show or reschedule of an appointment with less than 24 hours' notice. Our office requires 48 hours notifications if you are unable to keep your scheduled appointment. If less than 48 hours' notice is given, a $25 fee will be charged to your account. Patients with two missed appointments will be asked to transfer their records to another practice. If any first time appointment is missed, the patient will not be seen by the practice for future appointments.

Late Arrivals: We ask that you arrive 15 minutes prior to your scheduled appointment. If you arrive 15 minutes past your scheduled appointment time, you may be asked to reschedule.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the accounts, collections charge (if applicable) and any payments or credits applied to your account. Professional fees are the responsibility of the parent and/or guardian authorizing treatment; we cannot send statements to other persons.

Collections Charge: Your account will be transferred to a collections agency once it is 60 days past due.

- The responsible party agrees to pay all attorney fees and court costs associated with collecting payment for services rendered. Collection fees of approximately 50% are added to the account when it is turned over to the agency.

- I grant my permission for you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

- I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information.

Effective Date: Once you signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

I have read and understand the above policy and agree to abide by this policy.

_____ _____

Patient Signature (OR parent/Guardian) Date

ROYCE
FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICE

Our "Notice of Privacy Practices" document provides detailed information about the use and disclosure of your protected health information. You have the right to review the "Notice of Privacy Practices" document prior to signing this consent form Royce Family Dentistry encourages you to read our Notice of Privacy Practice in full.

Our "Notice of Privacy Practices" document is subject to change. You can obtain a copy of the current notice by contacting our organization and requesting that a revised copy be sent to you in the mail or given to you in person.

I, AS THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE, HA VE RECEIVED A COPY of Royce Family Dentistry "HIPPA NOTICE OF PRIVACY PRACTICES" document. If this acknowledgement of receipt is not obtained (i.e., emergency treatment situation), Royce Family Dentistry representative (witness) MUST document his/her good faith efforts to obtain the acknowledgement and the reason the acknowledgement was not obtained.

(Signature of Patient, Personal Representative of Patient, or Legal Guardian of Patient) Date

GOOD FAITH EFFORT AND REASON ACKNOWLEDGEMENT WAS NOT OBTAINED (DOCUMENTED BY Royce Family Dentistry)

◯ Patient refused to sign ◯ Patient unable to sign ◯ Other:

PERSONAL REPRESENATIVE AUTHORIZATION

A personal representative is anyone that you would like for Royce Family Dentistry to release your patient information to, including, but not limited to, prescription refills and/or samples, reasons for a particular visit, billing information, etc. **If there are no names listed below, we are assuming that you are declining your option to choose a personal representative. Upon doing so, please keep in mind that our office will not give out any information, including prescription refills, to anyone other than the patient or patient guardian.**

◯ I **do not wish** to select a personal representative.

◯ I authorize the following individual(s) to serve as my/patient's Personal Representative with full authority to access or authorize review, release and/or copying of my/patient's medical records:

_____ 2 _____

3 _____ 4 _____

◯ I authorize Royce Family Dentistry to leave detailed information in my voicemail box.

◯ I **do not** authorize Royce Family Dentistry to leave detailed information in my voicemail box.

◯ I authorize Royce Family Dentistry to send information via text messaging.

◯ I **do not** authorize Royce Family Dentistry to send information via text messaging.

◯ I authorize Royce Family Dentistry to send information via email messaging.

◯ I **do not** authorize Royce Family Dentistry to send information via email messaging.

I may revoke this request in writing at any time except to the extent that action based on this authorization has already taken place.

_____

(Signature of Patient, Personal Representative of Patient, or Legal Guardian of Patient) Date

If forms have been completed by someone other than the patient, please **print** name here:

_____

Date