PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Soc. Sec: _____ Drivers Lic. #: _____

E-Mail: _____ How did you hear about us? _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT):

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Soc. Sec: _____ Drivers Lic. #: _____

E-Mail: _____

PATIENT HEALTH INFORMATION: (PLEASE FILL ENTIRELY)

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

ARE YOU... (PREGNANT PATIENTS ARE REQUIRED TO HAVE A MEDICAL CLEARANCE BEFORE BEING SEEN)

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

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

☐ None ☐ Other; if yes, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

	Yes	No
AIDS/HIV Positive	☐	☐
Alzheimer's Disease	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis/Gout	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joint	☐	☐
Asthma	☐	☐
Blood Disease	☐	☐
Blood Transfusion	☐	☐
Breathing Problem	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chemotherapy	☐	☐
Chest Pains	☐	☐
Cold Sores/Fever Blisters	☐	☐
Congenital Heart Disorder	☐	☐
Convulsions	☐	☐

	Yes	No
Cortisone Medicine	☐	☐
Diabetes	☐	☐
Drug Addiction	☐	☐
Easily Winded	☐	☐
Emphysema	☐	☐
Epilepsy or Seizures	☐	☐
Excessive Bleeding	☐	☐
Excessive Thirst	☐	☐
Fainting Spells/Dizziness	☐	☐
Frequent Cough	☐	☐
Frequent Diarrhea	☐	☐
Frequent Headaches	☐	☐
Genital Herpes	☐	☐
Glaucoma	☐	☐
Hay Fever	☐	☐
Heart Attack/Failure	☐	☐
Heart Murmur	☐	☐
Heart Pacemaker	☐	☐
Heart Trouble/Disease	☐	☐

	Yes	No
Hemophilia	☐	☐
Hepatitis A	☐	☐
Hepatitis B or C	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Hives or Rash	☐	☐
Hypoglycemia	☐	☐
Irregular Heartbeat	☐	☐
Kidney Problems	☐	☐
Leukemia	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Lung Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Osteoporosis	☐	☐
Pain in Jaw Joints	☐	☐
Parathyroid Disease	☐	☐
Psychiatric care	☐	☐

	Yes	No
Radiation Treatments	☐	☐
Recent Weight Loss	☐	☐
Renal Dialysis	☐	☐
Rheumatic Fever	☐	☐
Rheumatism	☐	☐
Scarlet Fever	☐	☐
Shingles	☐	☐
Sickle Cell Disease	☐	☐
Sinus Trouble	☐	☐
Spina Bifida	☐	☐
Stomach/Intestinal Disease	☐	☐
Stroke	☐	☐
Swelling of Limbs	☐	☐
Thyroid Disease	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumors or Growths	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Yellow Jaundice	☐	☐

Have you had any serious illness not listed above? ☐ Yes ☐ No _____

Would you like information regarding treatment for sleep apnea? ☐ Yes ☐ No

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/GUARDIAN: _____ **DATE:** _____

Royal Dental Associates  Sousan Amiri, DDS, PA

INFORMED DENTAL CONSENT

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning any invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is risk associated with dental procedures and all of your questions have been answered.

Dental treatment and dental procedures are not to be taken for granted as routine or without the risk of complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are many variables involved, some predictable and others not. Complications in dentistry are very low but they do exist. Granted these are fairly uncommon occurrences but individuals who are contemplating treatment should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatments.

The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

I HAVE READ AND AGREE TO ROYAL DENTAL ASSOCIATES INFORMED DENTAL CONSENT:

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

APPOINTMENT POLICY

CANCELLATIONS:

Royal Dental Associates requires a **24HOUR NOTICE** for cancellations of reserved appointment times. We are aware and understand that emergencies do arise and will be reviewed on a "case by case" basis. Cancellations without **24HOUR NOTICE** will be considered failures and will incur a **$50 FAILED APPOINTMENT FEE**. Patients who do not come for up to 2 reserved appointments, have multiple late arrivals, or abuse scheduled appointment times, will no longer be appointed for dental care with the providers of Royal Dental Associates.

RESERVED APPOINTMENTS:

Arrival after **5 MINUTES** of your scheduled time may be disruptive to the next patient's care and will require that we reschedule your appointment and/or be placed as stand by. Please contact us at your earliest convenience to advise us if you think you will not arrive on time. Please note failure to arrive on time will constitute an appointment failure.

APPOINTMENT CONFIRMATION:

To allow us to provide quality care for all our patients Royal Dental Associates **REQUIRES** our patients to confirm their intent of keeping their scheduled appointment times **NO LATER THAN 2PM** on the business day prior to their reserved appointment. Failure to confirm will cause the appointment time to be released to another patient.

APPOINTMENT DEPOSIT REQUIREMENT:

Royal Dental Associates requires a **$50.00 DEPOSIT** for all appointments. The deposit operates as a credit on the patient account towards the total patient portion due before time of service. Royal Dental Associates requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. The deposit requirement is subject to our Cancellation Policy.

I HAVE READ AND AGREE TO ROYAL DENTAL ASSOCIATES APPOINTMENT POLICY:

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

4930 CENTRAL AVE
CHARLOTTE NC 28205
P: 704-ROYAL23 | F: 888-975-7633

Royal Dental Associates  Sousan Amiri, DDS, PA

ELECTRONIC DEVICE POLICY

To protect the comfort and privacy of all our patients, Royal Dental Associates **STRICTLY PROHIBITS THE USE OF ELECTRONIC DEVICES** (cell phones, cameras, video recording devices, etc.) in the clinical area. Royal Dental Associates believes strongly in protecting the privacy of our patients.

I HAVE READ AND AGREE TO ROYAL DENTAL ASSOCIATES ELECTRONIC DEVICE POLICY:

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

FINANCIAL POLICY

We accept the following forms of payment: Cash, Visa, Discover, American Express, and MasterCard. In addition, we offer CareCredit, LendingClub, and United Medical Credit, a patient payment program offering a full range of No Interest and Extended Payment Plans for treatment. All procedures involving lab work will require 50% down payment, then the remaining 50% balance will be due as treatment progresses. The balance must be paid before final insertion. Refunds will be reviewed on a case-by-case basis.

PATIENTS WITH INSURANCE COVERAGE:

Please understand that your insurance policy is a contract between you and your insurance company. Please note that although we strive to provide accurate information, such information is **NOT A GUARANTEE** of payment or eligibility with your insurance company and is only an **ESTIMATE**. All co-pays and deductibles are due prior to treatment. If your insurance company has not paid the claim within 60 days, the balance will be automatically transferred to you. The difference between our office dental fees and your insurance reimbursement is your responsibility. If you have dual coverage there may still be a portion that is your responsibility. The undersigner will be directly responsible for all charges and balances.

PATIENTS WITHOUT INSURANCE COVERAGE:

Patients without insurance coverage are required to pay for services prior to treatment.

I HAVE READ AND AGREE TO ROYAL DENTAL ASSOCIATES FINANCIAL POLICY:

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

OFFICE POLICY

Please understand that our providers need space to do their job. During medical surgery, it's understood family members are not allowed in the operatory so as to not contaminate the area or disturb the proceedings. Likewise, our providers need their operatories clear of distractions so they may concentrate on performing dental services. Royal Dental Associates believes strongly in protecting the privacy of all our patients. For this reason, we **DO NOT** allow anyone in the clinical area while patients are taken back into the operatory.

We ask that parents of children between 4yo and 17yo remain in the lobby when children are brought into the dental operatory. Studies and experience have shown that most children over the age of 3 react more positively when permitted to experience their dental visit on their own.

For the safety and privacy of all patients, other children who are not being treated should remain in the reception room with a supervising adult.

Through communication and trust, you can have a successful dentistry experience, with many more to come.

I HAVE READ AND AGREE TO ROYAL DENTAL ASSOCIATES OFFICE POLICY:

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

4930 CENTRAL AVE
CHARLOTTE NC 28205
P: 704-ROYAL23 | F: 888-975-7633

Authorization for Release of Information – Compound Release

Name of Patient_____ Date of Birth _____

Royal Dental Associates is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment Reminders ☐ Other_____
☐ Other person (s) (provide name and phone number)(Spouse, Parent, Stepparent, Grandparent etc)	☐ Financial ☐ Treatment
☐ Email communication-Provide email address* _____	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive r text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Jan 2018

Royal Dental Associates

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____