Date______________ ROYAL KUNIA DENTAL, INC. Last Update____________

Patient Name	Social Security Number	Home Phone ( )
Home Address	City, State, Zip	Cell Phone ( )
E-MAIL ADDRESS = PLEASE PRINT CLEARLY		Work Phone ( )
Marital Status __ Single __ Divorced __ Married __ Separated / __ Male __ Female	Birthday / /	Drivers License and State

Primary Insurance Co. ____________________Group____________Subscriber________________

Secondary Insurance Cl. ____________________Group____________Subscriber________________

RESPONSIBLE PARTY

Name	Social Security Number	Home Phone
Home Address	City, State, Zip	Birthday / /
Martial Status ___Single __Divorced ___Married __Separated / ___ Male ___ Female	Relationship to Patient:	Drivers License and State
Employer	Occupation	Work Phone
Spouse's Name	Social Security Number	Birthday / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone

How did you hear about our Office?

Who Selected this Office? Self____ Spouse____ Parent____ Employer____ Insurance Co.____ Other____

Where did you find the Phone Number to this Office?________________________________

___Referred by Friend ___Yellow Pages ___Relative ___Insurance Plan ___ Internet ___Newspaper ___ Other

___Direct Mailing ___TV / Radio Ad If you were referrred, whom may we thank?______________________

CONSENT

* I will answer all health questions to the best of my knowledge. _________ (Initials)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

SIGNATURE ______________________ DATE ____________ Relationship to Patient ______________

THERE MAY BE A CHARGE FOR ANY MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELED 24 HOURS BEFORE YOUR APPOINTMENT. (Initials)____________

Terms and Conditions

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a Condition of treatment by this office. I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I Hereby authorize release of any information needed and also authorize my insurance company to pay directly to This Office benefits accuring to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceeding shall be intitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

SIGNATURE ______________________ DATE ____________

Why have you come to see us today? (e.g: Pain, Checkup, Etc..)____________________

Previous Dentist____________________ Last Visit______________ Date of Last Cleanig______________

What problems have you had with past dental treatment?____________________

How often do you brush?____________________ Do you floss? Yes__________ No____________

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I perfer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straighter.

What are you dental priorities?____________________
(e.g: appearance, dentle health, financial considerations, etc…)

I consider my health to be (check one): ____Excellent ____Good ____Fairl ____Poor

Do you have or have you had any of the following? Please circle Y for yes or N for no.

Y N Heart Disease
Y N Heart Murmur/Mitral Valve Prolapse
Y N Stroke
Y N Congenital Heart Lesions
Y N Rheumatic Fever
Y N Pacemaker
Y N Stent
Y N Blood Pressure HIGH____ LOW____
Y N Anemia
Y N Prolonged Bleeding Disorder
Y N Tuberculosis or Lung Disease
Y N Asthma
Y N Hay Fever
Y N Sinus Trouble
Y N Epilepsy/Seizures
Y N Ulcers
Y N Implants/Artificial Joints: Hip- Knee_____ Other____________________

Y N Liver Disease
Y N Jaundice
Y N Hepatitis Type______
Y N Diabetic Type______
Y N Excessive Urination and/or Thirst
Y N Infectious Mononucleosis ("Mono")
Y N Herpes
Y N Arthritis
Y N Sexually Transmitted Disease
Y N Kidney Disease
Y N Tumor or Malignancy
Y N Cancer/Chemotherapy
Y N Radiation/Therapy
Y N History of Drug Addiction

Doctor Notes Only:

Y N HIV
Y N Aids
Y N Immune Suppressed Disorder
Y N Hearing Loss
Y N Fainting Spells
Y N Glaucoma
Y N History of Emotional or Nervous Disorders

WOMEN:
Y N Are you taking birth control medication?
Y N Are you or could you be pregnant or nursing?

Y N I smoke or use chewing tobacco. If yes, how much per day?_________ How may years?___________
Y N I have consumed alcohol within the last 24 hours.
Y N I usually take an antibiotic prior to dental treatment.
Y N Have you ever taken Fen-Phen or Redux?________
Y N I have had major surgery: Year_____ Type of operation_____________ Year_____ Type of operation________________

Y N Do you have any other medical problem or medical history NOT listed on this form?____________________

Are you allergic to any of the following?
Please Circle Y for yes or N for no

Y N Aspirin
Y N Ibuprofen
Y N Sulfa Drugs/Sulfites/Sulfides
Y N Penicillin
Y N Codeine
Y N Latex, Metals, Plastics
Y N Local Anesthetics (Novocaine)
Y N Other Medications?____________

Please list all medications you are currently taking:

Medicine________________ **Condition**________________________
Medicine________________ **Condition**________________________
Medicine________________ **Condition**________________________
Medicine________________ **Condition**________________________

In the event of an emergency please contact:

Name____________________ **Relationship**________________ **Phone**________________
Name____________________ **Relationship**________________ **Phone**________________

Initial Medical/dental health reviewed by:

X____________________ ________ ____
Doctor's Signature **Date**

X____________________ ________
Patient or Guardian Signature **Date**

Periodic medical/dental health reviewed by:

X____________________ ____
Doctor's Signature **Date**

Periodic medical / dental health reviewed by:

X____________________ ________
Patient or Guardian Signature **Date**