RoyDental

Thank you for choosing **Roy Dental**! We will strive to provide you with the best possible dental care. To help us meet your entire oral healthcare needs, please fill out all the forms completely. If you have any questions or need assistance, please ask us, we will be happy to help.

New Patient Information Form

Today's Date ___/___/_____

Patient Name: First_____MI_____Last_____Nickname _____

Address: Street_____City_____State_____Zip _____

Phone: Home_____Work_____Mobile _____

SSN:_____**DOB:** ___/___/_____ **Drivers License # :**_____ **State**_____

Patient Employed By_____Occupation_____Phone _____

Address: Street_____City_____State_____Zip _____

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

In case of emergency, who should be notified? _____

Relationship to Patient_____Home Phone_____Mobile Phone _____

Is the patient a Minor? ☐Yes ☐No **Full-time Student** ☐Yes ☐No **Name of School** _____

Name of Responsible Party: First_____Last _____

Date of Birth_____**Relationship to Patient** ☐Self ☐Spouse ☐Parent ☐Other _____

If patient is a Minor, primary residency ☐Both Parents ☐Mom ☐Dad ☐Step Parent ☐Shared Custody ☐Guardian

Address: *(if different from patient)* Street_____City_____State_____Zip _____

Phone: Home_____Work Mobile _____

Employer *(if different from above)*_____Occupation_____Phone _____

Address: Street_____City_____State_____Zip _____

Whom may we thank for referring you?

☐One of our valued patients (name of patient) _____

☐Advertisement_____☐Local Dental Society _____

☐Our Website_____☐Other _____

2950 Whipple Avenue,Suite #9 Redwood City,CA-80528
Tel: (650) 368-6333;Fax: (650) 368-1409; Email info@roydental.net
www.roydental.net

Please list other members of your immediate family who are patients in our practice:

1) _____ **2)** _____ **3)** _____

Dental Benefit Plan Information

Primary Dental Plan Name_____ Phone _____

Address: Street_____ City_____ State_____ Zip _____

Name of Insured_____ Date of Birth_____ ID Number _____

Policy Number_____ Patient Relationship to Insured _____

Secondary Dental Plan Name_____ Phone _____

Address: Street_____ City_____ State_____ Zip _____

Name of Insured_____ Date of Birth_____ ID Number _____

Policy Number_____ Patient Relationship to Insured _____

Secondary Dental Insurance Information

Plan Name_____ **Phone** _____

Address: Street_____ **City**_____ **State**_____ **Zip** _____

Name of Insured_____ **Date of Birth**_____ **ID Numbe**r _____

Policy Number_____ **Employer** _____

Patient Relationship to Insure _____ Deductible Amount _____

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

My email address is _____

☐ I consent only t o receiving appointment reminders via email I understand I can withdraw my consent at any time.

My email address is _____

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Roy Dental can use **Text** notification as a form of appointment reminder, that way confirming appointments will be extremely convenient on your part. STANDARD DATA FEES AND TEXT MESSAGING RATES MAY APPLY BASED ON YOUR PLAN WITH YOUR MOBILE PHONE CARRIER. As mobile access and text message delivery is subject to your mobile carrier network availability, such access and delivery is not guaranteed.

☐ I consent receiving information via Text. I understand I can withdraw my consent at any time.

My cell phone number is _____

☐I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I understand that providing the incorrect information can be dangerous to my health. I hereby, authorize Dr Paramita Roy and her team to perform any necessary dental procedures and dental treatment deemed necessary during diagnosis.
_____ (Initial)

I have read and agree to the financial and scheduling terms._____(Initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One)
_____(initial)

I hereby acknowledge that a copy of this practice's **Notice of Privacy Practices** has been made available to me.

I have been given the opportunity to ask any questions I may have regarding this Notice.____(Initial)

I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me.

I have been given the opportunity to ask any questions I may have regarding this Fact Sheet._____(Initial)

Signature_____Date_____

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