



In order to help us render the proper services to you, please fill out the following form completely.

**I. Patient:**

Patient Name \_\_\_\_\_ Male  Female  Date \_\_\_\_\_  
 Address \_\_\_\_\_ LAST FIRST MIDDLE Birthdate \_\_\_\_\_ MO. DAY YR. Age \_\_\_\_\_  
 City / State / Zip \_\_\_\_\_  
 Bank Name \_\_\_\_\_  
 Driver's License # \_\_\_\_\_ Bank Account #'s: Checking \_\_\_\_\_ Savings \_\_\_\_\_  
 Previous Address (if less than 6 months at present address) \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 Martial Status:  Single  Married  Head of Household  
**If Married:**  
 Spouse's Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
**Whom May We Thank For Referring You?** \_\_\_\_\_  
 Have any family members been seen in our office? \_\_\_\_\_  
 IN CASE OF EMERGENCY: Name of nearest adult relative not living with you \_\_\_\_\_  
 Relation \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Name, address & phone number of a personal friend \_\_\_\_\_  
**Dental Insurance Companies:**  
 Primary Carrier Name \_\_\_\_\_  
 Employee Name \_\_\_\_\_ Employee Social Security # \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Relationship to Employee  Self  Child  Spouse  Other \_\_\_\_\_  
 Group Plan Number \_\_\_\_\_ Group Number \_\_\_\_\_ Union Number \_\_\_\_\_  
 Employer Name \_\_\_\_\_  
 Secondary Carrier Name \_\_\_\_\_  
 Employee Name \_\_\_\_\_ Employee Social Security # \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Relationship to Employee  Self  Child  Spouse  Other \_\_\_\_\_  
 Group Plan Number \_\_\_\_\_ Group Number \_\_\_\_\_ Union Number \_\_\_\_\_  
 Employer Name \_\_\_\_\_

**II. Person Responsible for Account:**

Name \_\_\_\_\_  
*If person responsible is different from above patient - then fill out the following:*  
 Address \_\_\_\_\_  
 City / State / Zip \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Birthdate \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Employer Address \_\_\_\_\_

Medical Update	
DATE	SIGNATURE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**III. Dental-Medical History** Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No
Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies .....		
High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	a. Penicillin .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder-anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	b. Other Antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Tumor History .....	<input type="checkbox"/>	<input type="checkbox"/>	c. Codeine, Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	d. Local anesthetic, novocain .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid dis., hyperthyroidism .....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	e. Others .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis, Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	Aids .....	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	HIV .....	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver or Kidney Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	How many months? .....		
Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control .....	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic Joint .....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Valve .....	<input type="checkbox"/>	<input type="checkbox"/>
			Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>			

Has a physician ever advised you that you needed to be premedicated for dental treatment? \_\_\_\_\_

Name of Physician (M.D.) \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Date you last saw physician \_\_\_\_\_ Are you under medical treatment now? \_\_\_\_\_

Have you been hospitalized in the past year? \_\_\_\_\_ Reason \_\_\_\_\_

What medicines are you taking now?	If so - Reason?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

1. Reason for dental visit \_\_\_\_\_  
 Last Dental Visit \_\_\_\_\_  
 Previous Dentist Name \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 2. Are you pleased with the appearance of your teeth? .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you ever awaken with a headache without a good reason for it? .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you ever have an unexplained ringing, hissing or buzzing sound in your ears ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are your teeth sensitive to heat? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are your teeth sensitive to cold? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are your teeth sensitive to pressure? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are your teeth sensitive to sweet? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are your teeth sensitive to sour? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any teeth removed (other than wisdom teeth)? .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have they been replaced? (Crowns, Bridges, Implants, etc.) .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had orthodontic treatment? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have problems with bleeding gums? .....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have frequent bad breath or unpleasant taste in your mouth? .....            | <input type="checkbox"/> | <input type="checkbox"/> |

Please sign after answering the above. Thank you. \_\_\_\_\_  
SIGNATURE

Is there anything other about your general health that we should know to better serve you? \_\_\_\_\_

**IV. Agreement of Financial and Personal Responsibilities:**

In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply to our office. The responsible party agrees to:

1. Pay the doctor at the time treatment or service is received or by previous arrangements.
2. That if payments are extended beyond 30 days from the date of first billing to pay 1 1/2% per month on the unpaid balance (annual rate of 18%) with a minimum charge of \$1.00 per month.  
I further agree to pay for all legal fees and costs reasonably incurred in connection therewith. Interest not paid when due shall be added to and become part of the principal.
3. A \$20.00 charge will be assessed on all returned checks.
4. In the event my insurance company does not cover the entire balance of this account within 45 days from the date of service, I agree to pay the balance in full.
5. Personal credit may be checked.

**V. Insurance Information:**

We are more than happy to help you by submitting your insurance for you without charge. We make every effort to get your insurance out the same week. In some instances, the insurance company takes an extraordinary amount of time to process the claim causing you finance charges after 30 days. Insurance enables you to get financial help in paying for a portion of your dental bill. We try our best to estimate what the insurance will pay, but it is only an estimate. Our agreement is with you, not the insurance company. If there is any additional treatment necessary, we will discuss it with you before proceeding.  
 I understand that if there is a balance after my insurance has been paid that I am financially responsible.  
 I hereby authorize any insurance company to release all information with bearing on the benefits payable under this or any other plan providing benefits or service.  
 I authorize payment of benefits directly to the provider of service.

**VI. If Patient is a Minor:** I hereby grant permission for dental treatment to be performed on this minor and will assume all responsibilities connected with such treatment.

**VII. If Medications Are Given:** I understand that I **Should Not** mix prescribed medication with alcoholic beverages and understand that I **Should Not** operate any vehicle or hazardous device when taking a narcotic or sedative medication. Since a change of medical condition or medication can affect dental treatment, I understand the importance of and agree to notify Dr. Robison of any changes at any subsequent appointment. **I understand that there may be a \$42 fee for a missed appointment with less than 24-hour notice.**

By signing below I have read and understand the above and agree to the terms therein.

X \_\_\_\_\_