Patient Registration and Medical History

Home Phone:______________________ Cell Phone:_________________ Email Address:_________________________

Preferred Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Patient Name:____ Preferred Name:___________________________

Street Address:____ City:__________ State:_________ Zip:__________

Sex: ☐ Male ☐ Female Age:__________ Birthdate:__________________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer:____ Occupation:_________________________________

Business Address:_____________________________________ Work Phone:_________________________________

Spouse Employed by:__________________________________ Occupation:_________________________________

Business Address:_____________________________________ Work Phone:_________________________________

Who is responsible for this account?_________________________ Relationship to Patient:_______________________

Social Security Number:_______________________________ Spouse's Social Security Number: ___________________

Name of Dental Insurance Company:__________________________________ Group Number:___________________

In case of emergency, who should be notified?_____________________________ Phone:_________________________

Whom may we thank for referring you?____

Medical History

Physician's Name:_____________________________________ Date of Last Physical:___________________________

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ High/Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Medications for Bones like Fosamax, Boniva or Actonel
- ☐ Prosthetic Joints
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Radiation Therapy/Chemotherapy to head, neck or jaw
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ A.I.D.S. or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia
- ☐ Coumadin, Anti Coagulation Therapy

Do you have any allergies or have you ever had an adverse reaction to any medication? ☐ Yes ☐ No If yes, what?___________

____

Have you ever responded adversely to medical or dental treatment?____

Are you taking any medication at this time? ☐ Yes ☐ No If yes, what?_______________________________________

____

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what?____________________________________

Have you had any surgeries or operations? ☐ Yes ☐ No If yes, for what?____________________________________

Have you been hospitalized in the last 2 years? ☐ Yes ☐ No If yes, for what?____________________________________

Ladies: Could you be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?____

____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or emissions that I may have made in the completion of this form.

Date:_______________________ Signature:____

Assignments of Benefits:

I authorize payment of benefits to Alan F. Robinson DDS, PC. Signed (Insured/Authorized Person)

____ Date:_____/_____/______

Release of Information:

I authorize the release of any information necessary to process insurance claims. I also authorize release of information to other practitioners or other persons as deemed necessary by Alan F. Robinson DDS, PC. Signed (Insured/Authorized Person)

____ Date:_____/_____/______

Authorization to Treat:

I authorize Alan F. Robinson DDS and/or staff or designated provider to provide treatment as deemed necessary.

This authorization shall remain in effect until withdrawn by written notice. Authorization includes minor/dependent children.

Signed (Insured/Authorized Person) ____ Date:_____/_____/______

The Practice of Alan F. Robinson DDS, PC
Acknowledgment of Receipt of this Practice's Privacy Notice

I acknowledge that I have received, and/or reviewed the notice of the Privacy practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of the practices Privacy Practices is posted in the office where I can review it if desired.

____ ____________________

Patient or Patient Representative or Parent if patient is under 18 Date

Documentation of "Good Faith Effort"

Patient Name: ____ Date:_____/_____/______

The patient presented for treatment on this date, and was provided the practices Privacy Notice. A good faith effort was made to obtain written acknowledgment of receipt. A written acknowledgment was not obtained because:

________ Patient refused to sign, with the reason ____

________ Patient is unable to sign due to: ____

________ There was a medical emergency preventing timely signature, and an attempt will be made to obtain acknowledgment later.

________ Other:____

____

Signature of employee completing this form