

## 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: \_\_\_\_\_ Birth date: \_\_\_\_\_

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):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Special Diet                          |
| <input type="checkbox"/> High/Low Blood Pressure                                  | <input type="checkbox"/> Headaches  | <input type="checkbox"/> Swollen Neck Glands                   |
| <input type="checkbox"/> Circulatory Problems                                     | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease                   | <input type="checkbox"/> Rheumatic Fever                       |
| <input type="checkbox"/> Nervous Problems   | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Sinus Problems                        |
| <input type="checkbox"/> Radiation Treatment                                      | <input type="checkbox"/> Psychiatric Care                                       | <input type="checkbox"/> A.I.D.S. or Other                     |
| <input type="checkbox"/> Artificial Heart Valves or Joints                        | <input type="checkbox"/> Chronic Diarrhea                                       | <input type="checkbox"/> Immunosuppressive Disorders           |
| <input type="checkbox"/> Recent Weight Loss                                       | <input type="checkbox"/> Allergies to Anesthetics                               | <input type="checkbox"/> Stroke                                |
| <input type="checkbox"/> Back Problems  | <input type="checkbox"/> Allergies to Medicine or Drugs                         | <input type="checkbox"/> Ulcer                                 |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> General Allergies                                      | <input type="checkbox"/> Venereal Disease                      |
| <input type="checkbox"/> Respiratory Disease                                      | <input type="checkbox"/> Blood Disease  | <input type="checkbox"/> Chemical Dependency                   |
| <input type="checkbox"/> Medications for Bones<br>like Fosamax, Boniva or Actonel | <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Hemophilia                            |
| <input type="checkbox"/> Prosthetic Joints  | <input type="checkbox"/> Radiation Therapy/Chemotherapy<br>to head, neck or jaw | <input type="checkbox"/> Coumadin, Anti Coagulation<br>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 omissions that I may have made in the completion of this form.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## Releases & Authorizations

### 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