Patient Registration and Medical History

LAKESIDE CENTER FOR IMPLANT DENTISTRY

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):

- ☐ 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 a preferred pharmacy? Name: _____City, State: _____Phone:_____

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:_____

Releases & Authorizations

LAKESIDE CENTER
FOR IMPLANT DENTISTRY

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

Dear Patients,

Due to the constant changes in insurance, it is no longer an easy job to interpret each individual policy or determine exactly what will be paid by your insurer before processing. Although, we do our best to do so, it is not always possible.

We accept all insurances; however we do not participate with any insurance. We will collect estimated patient responsibility at the time of services and will bill your insurance along with all the supporting information necessary for your insurance company to pay the claim.

Delta Dental patients: Delta Dental is a special case in that they will not pay our office. They will make payment directly to you. Therefore, we must bill you. However, some plans will not pay you as we are a non-participating provider. Please be sure to know your insurance plan. A preauthorization is recommended.

Please remember that YOUR insurance policy is between you, your employer and/or your company and we are a third party. We will do everything possible to assist you in this regard.

Patient Signature: _____ Date:_____/_____/_____