

PATIENT REGISTRATION

Date _____

Patient Information

Patient's Name _____ Male Female
Preferred Name _____ Birthdate _____
Marital Status Single Married Divorced Widow Social Security # _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____
Employer _____ Work Phone _____
City _____ State _____ Zip _____
E-mail Address _____ Home Phone _____

Responsible Party Information

Parent (Use parent insurance policy is through)/ Spouse of above _____
Address _____ Phone _____
City _____ State _____ Zip _____
Employer _____ Work Phone _____
Address _____ State _____ Zip _____
Cell Phone _____ Driver's License # _____

Insurance Information

First Insurance _____ Group # _____
Name of Policy Holder _____ Relationship to Patient _____
Birthdate _____ ID or SS # _____
Source of Insurance (i.e. Union #, Employer, etc.) _____
Second Insurance _____ Group # _____
Name of Policy Holder _____ Relationship to Patient _____
Birthdate _____ ID or SS # _____
Source of Insurance (i.e. Union #, Employer, etc.) _____

I hereby authorize payment to Robinson Family Dental of benefits payable to me under the above policy. I also authorize Robinson Family Dental to release to the above insurance all information needed to process claims.

Signature of Insured Person _____ Date _____

Financial Responsibility

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid; in whole or in part, by dental care payor.

I further understand that, if collection costs are incurred by Robinson Family Dental for payment of my unpaid balance, I am responsible for payment of all charges.

Signature of responsible party _____ Date _____

Emerg. Contact

Name of person we should contact in case if emergency _____

Relationship _____ Phone _____

HELP US IMPROVE

How did you find out about Robinson Family Dental? Yellow Pages Direct Mail Web Site
Other _____

Referral; whom may we thank? _____ Relationship _____

Why did you choose Robinson Family Dental? Expertise Location Hours Cost

Other _____

Contact Info.

What is your preferred method to be contacted? E-mail Cell Phone Home Phone
 Text Message US Mail (you may check more than one option)

***THIS INFORMATION WILL NOT BE SOLD OR USED FOR OTHER PURPOSES ***

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
 Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
 Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
 Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
 Do you take, or have you taken, Phen-Fen or Redux? Yes No
 Are you on a special diet? Yes No
 Do you use tobacco? Yes No
 Do you use controlled substances? Yes No
 Do you need to pre-medicate? Yes No If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No
 Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____