Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date: _____

E-mail Address: _____

Name: _____
Last First MI Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Hm #: (____)_____ Cell / Other #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Relative or Friend not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

Insurance

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #:(____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Continued on Back

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (_____)_____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Fosamax or any other bisphosphonate? ☐ Yes ☐ No

If so, when? _____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Herpes / Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease / Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack / Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have mobility in your teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature Date

Office Use Only

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Medical History Update

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____ _____

Patient Signature Date

_____ _____

Dentist Signature Date

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____ _____

Patient Signature Date

_____ _____

Dentist Signature Date

ROBINSON
FAMILY DENTISTRY
Building Smiles Daily

2015 HIPPA Agreement

CONSENT FOR USE AND DISCLOSE OF HEALTH INFORMATION

Please read the following statements carefully and sign at the bottom of the page

PURPOSE OF THE CONSENT: We have a duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The notice also describes your legal rights and our obligations regarding the use and disclosure of your medical information. By signing this form, you will consent to our use and disclosure of your picture and protected health information to carry out treatment, payment activities, healthcare options and electronic filing of your insurance claims.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, health information, and of our other important matters about your protected health information. A copy of our notice accompanies this consent upon request. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person. Please understand that revocation of the consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: We will gladly furnish you with a set of our Privacy Practices Notice upon request at any time, if any time you have questions or concerns regarding this law, please feel free to ask us.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: We may use or disclose identifiable health information about you for many reasons, including treatment, payment, healthcare operation, public health purposes, auditing, national security and protective services, worker's compensation, lawsuits and disputes, activities of managed care networks in which we participate, activities of our affiliates, appointment reminders, law enforcement purposes, to avert a serious threat to health or safety, military command authorities, and required by law.

COMPLAINTS: If you believe your rights have been violated, you may file a written complaint with this office at ***Kit Robinson, D.M.D., Attn: Privacy Officer, P.O. Box 603 Hahira, Georgia 31632*** or with the Secretary of the U.S. Department of Health and Human Services.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

FAMILY MEMBERS I GIVE PERMISSION TO RELEASE INFORMATION TO:

1) _____ _____
NAME RELATIONSHIP

2) _____ _____
NAME RELATIONSHIP

950 Georgia Hwy 122 W · P.O. Box 603 · Hahira, GA 31632
Phone: 229.794.3003 · Fax: 229.794.3804 · www.KitRobinsonDMD.com

ROBINSON
FAMILY DENTISTRY
Building Smiles Daily

Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available. We are also committed to providing you with up to date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to provide you with excellent service while minimizing our administrative costs.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time services are provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks and all major credit cards. Outside financing through Care Credit is available upon request and approval.

All charges are your responsibility. We must emphasize that as your dental care provider, our relationship is with you, our patient, not your insurance company. As a courtesy to you we will help you by processing all of your insurance claims. In order for our office to file your insurance claim, you must provide us with up to date information. It is your responsibility to notify our office of any insurance changes so that claims may be submitted properly at all times.

- Return checks are subject to $30.00 fee.
- **Appointments that are canceled without the proper 24 hour notice will be assessed a $30.00 reinstatement fee.**
- Any accounts that are 60 days past due will be referred to the County Magistrate Court in your county to be processed for wage garnishment.

Please refer any questions you may have to any member of our team. Robinson Family Dentistry is committed to providing you with a comfortable and positive experience.

_____ _____

Name (Please Print) Signature

_____ _____

Date Witness

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