BART F. ROBISON, DDS, PS

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PRACTICE LIMITED TO ENDODONTICS

PATIENT REGISTRATION FORM

Please Fill Out Completely

Name: ______ Birthdate: ______ General Dentist: ______

Address: ______ City: ______ State: ______ Zip Code: ______

Home Phone: ______ Cell Phone: ______ SSN #: ______

Employers Name: ______ Phone: ______

Parent or Guardian (if minor) Name: ______ SSN #: ______

Primary Insurance Co: ______

Group #: ______ Phone: ______

Employer: ______

Employee if other than patient: ______

Name: ______

Birthdate ______ SSN #: ______

Secondary Insurance Co: ______

Group #: ______ Phone: ______

Employer: ______

Employee if other than patient: ______

Name: ______

Birthdate: ______ SSN #: ______

Physician's Name and Phone #: ______

Are you under medical treatment? ❑Y ❑N Have you been recently hospitalized? ❑Y ❑N If yes - for what? ______

Do you have any bleeding problems? ❑Y ❑N Have you ever been told you need to premedicate with antibiotic due to heart condition or joint replacement? ❑Y ❑N

Have you ever taken Fen-phen or other weight loss medication? ❑Y ❑N Are you currently taking any medications? ❑Y ❑N (Please list below in space provided)

Medications: ______

______

Do you have allergies or adverse reaction to any of the following? -- If so please check yes to any that may apply

❑ Penicillin ❑ Asprin ❑ Ibuprofen ❑ Sulfa ❑ Codeine ❑ Latex ❑ Other antibiotics ❑ Local anesthetic ❑ Other ______

Please check any of the following you presently have or have had:

❑ Anemia	❑ Colitis	❑ HIV/AIDS	❑ Radiation therapy	❑ Thyroid treatment
❑ Angina	❑ Cancer	❑ Hepatitis	❑ Scarlet fever	❑ Ulcers
❑ Asthma	❑ Diabetes	❑ Herpes	❑ Stroke	❑ Rheumatic fever
❑ Arthritis	❑ Heart problem	❑ Head/neck injury	❑ Seizures	❑ Sinuitis
❑ Blood disease	❑ Heart murmur	❑ Kidney disease	❑ STD's	❑ Joint replacement
❑ Blood transfusion	❑ Heart attack	❑ Liver disease	❑ TB	❑ Other ______
❑ Chemotherapy	❑ High blood pressure	❑ MVP	❑ TMJ	❑ Other ______

Women Only: Are you taking oral contraceptives? ❑Y ❑N Are you or could you be pregnant? ❑Y ❑N Are you nursing? ❑Y ❑N

AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

I certify that I have read, understand, and answered the above information to the best of my knowledge. I understand that providing incorrect health information may be dangerous to my health and that I have answered all questions accurately.

I authorize Dr. Robinson to release any information including diagnosis and records of treatment or examination rendered to me or my dependent to third party payors and or health care provider(s).

I authorize and request that my insurance pay direct to Dr. Robinson any benefits payable to me. I understand that my insurance carrier may pay less than full cost of service.

I understand that Dr. Robinson does not guarantee my insurance benefits and I agree to be responsible for all fees regardless of insurance coverage. In the event payment is not received within 30 days of due date, I agree to pay interest of 12% annually (1% per month) and all costs of collection including, but not limited to, reasonable legal and or attorney fees.

Signature ______ Date ______