



BART E. ROBISON, DDS, PS

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PATIENT REGISTRATION FORM

Please Fill Out Completely

PRACTICE LIMITED TO ENDODONTICS



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 Aspirin Ibuprofen Sulfa Codeine Latex Other antibiotics Local anesthetic Other _____

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

<input type="checkbox"/> Anemia	<input type="checkbox"/> Colitis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Radiation therapy	<input type="checkbox"/> Thyroid treatment
<input type="checkbox"/> Angina	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herpes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart problem	<input type="checkbox"/> Head/neck injury	<input type="checkbox"/> Seizures	<input type="checkbox"/> Sinuitis
<input type="checkbox"/> Blood disease	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> STD's	<input type="checkbox"/> Joint replacement
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Liver disease	<input type="checkbox"/> TB	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> MVP	<input type="checkbox"/> TMJ	<input type="checkbox"/> 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. Robison 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. Robison any benefits payable to me. I understand that my insurance carrier may pay less than full cost of service.

I understand that Dr. Robison 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 _____