



Patient Registration and Authorization

Please Fill Out Completely

Bart F. Robison DDS, PS
16521 13th Ave. W. Suite 101
Lynnwood WA 98037
(425)743-3054 Fax (425)743-3093

Patient

Name: _____
Date Of Birth: _____ SSN _____ General Dentist: _____
Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Work #: _____
Employer Name & Phone: _____
Responsible Party If A Minor: _____ Date Of Birth: _____

Emergency Contact: _____
Relationship To Patient: _____ Phone: _____

Primary Dental Insurance & Address: _____
Subscriber Name: _____ Date Of Birth: _____
Subscriber ID # Or SSN: _____ Group Or Policy #: _____

Secondary Dental Insurance & Address: _____
Subscriber Name: _____ Date Of Birth: _____
Subscriber ID # Or SSN: _____ Group Or Policy #: _____

Missed Appointments: Please provide 24-hour notice to cancel or reschedule an appointment. Less than 24-hour notice may be documented as a missed appointment. Missed appointments will be assessed a \$50.00 fee.

I hereby authorize you and/or your assignees to contact me at any telephone numbers, including cell phone numbers, provided by me or otherwise obtained by you, and to leave messages on these devices.

I authorize treatment of the person named above and agree to accept full financial responsibility for payment regardless of third-party responsibility. I authorize the release of any medical information requested by my insurance company. I authorize payment of benefits directly to my Providers office. Finance charges maybe charged to balances over 60 days at the rate of 9% per annually. If my account becomes past due, I/we agree to pay all attorney fees, court costs, filing fees and process service fees which may be assessed by any collection agency or law firm retained to pursue the matter and for the venue and jurisdiction to be in Snohomish County.

I certify that all the information is correct and that I have read, understand and agree to the above statements.

Patient Signature & Date



Patient Health History

Please Fill Out Completely

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Patient Name: _____ Date Of Birth: _____ M/F

Physician's Name &
Phone: _____ Pharmacy _____

Are You Under Medical Care? **Y/N** Have You Been Recently Hospitalized? **Y/N** If yes-for what? _____
Do You Have Any Bleeding Problems? **Y/N** Have You Ever Taken Weight Loss Medication? **Y/N** **Have You Ever Been Told You Need to Pre-medicate With Antibiotics Due to Heart Conditions or Joint Replacement? Y/N**
Are You Currently Taking Any Medication? **Y/N** (Please List) _____

Do You Have Any Allergies or Adverse Reaction to Any of The Following? **Y/N**

- | | | | |
|-------------------------------------|------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Latex | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Codeine | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other Antibiotic |

Do You Have or Had:

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Radiation | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Therapy | <input type="checkbox"/> Joint |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Replacement |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Colitis/IBS | <input type="checkbox"/> Head/Neck Injury | <input type="checkbox"/> Seizures | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> TB | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TMJ | <input type="checkbox"/> High Blood |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> MS | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Pressure |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> MVP | <input type="checkbox"/> Treatment | |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Ulcers | <input type="checkbox"/> None |
| <input type="checkbox"/> Heart Murmur | | <input type="checkbox"/> Rheumatic Fever | |

Women Only: Are You Taking Oral Contraceptives? **Y/N** Are You/Could You Be Pregnant? **Y/N** Are You Nursing? **Y/N**

I certify that I have read, understand, and answered the above information to the best of my knowledge understand that providing incorrect health information may be dangerous to my health and that I answered all questions accurately. I understand and authorize Dr. Robison to release medical information to other Health Care Providers and Insurance Carriers.

We are required by law to maintain the privacy of and provide individuals with a notice of our Legal duties and privacy practices with respect to protected health information. I acknowledge that I have been provided with and read the HIPAA Notice of Privacy Practices.

Patient Signature & Date