Patient Registration and Authorization

Please Fill Out Completely

Bart F. Robison DDS, PS
Brigitte Bigras DMD
3710 169th St. N. E. Bldg. D101
Arlington WA 98223
(360)651-9394 Fax (360) 651-9262

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

- ☐ Penicillin
- ☐ Sulfa
- ☐ Ibuprofen
- ☐ Codeine
- ☐ Latex
- ☐ Aspirin
- ☐ Other_____
- ☐ Other Antibiotic

Do You Have or Had:

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

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