PATIENT NAME _____ / ___ / ____

(LAST) (FIRST) (MIDDLE INITIAL) DATE OF BIRTH

CIRCLE THE APPROPRIATE ANSWER

COMMENTS

1. PHYSICIAN'S NAME _____
   ADDRESS _____
   CITY _____
2. HAVE YOU EVER HAD A SERIOUS ILLNESS OR OPERATION? YES NO
   IF SO, PLEASE EXPLAIN. WHEN? _____ WHAT? _____
   _____
3. ARE YOU UNDER A PHYSICIAN'S CARE? YES NO
   IF SO, FOR WHAT REASON _____
   _____
4. WHEN WAS YOUR LAST COMPLETE PHYSICAL EXAM? _____
5. ARE YOU TAKING ANY MEDICATIONS? YES NO
6. DO YOU HAVE ANY ALLERGIES? YES NO
   ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO
   ARE YOU ALLERGIC TO PENICILLIN, ANTIBIOTICS, OR ANESTHETICS? YES NO
7. HAVE YOU BEEN TREATED FOR OR ADVISED YOU HAVE HEART DISEASE? YES NO
   DO YOU HAVE A PACEMAKER OR AN ARTIFICAL HEART VALVE IMPLANT? YES NO
   ARE YOU AWARE OF ANY HEART MURMURS? YES NO
   HAVE YOU EVER HAD RHEUMATIC FEVER? YES NO
8. HAVE YOU EVER HAD SURGERY, RADIATION TREATMENT OR CHEMOTHERAPY FOR A TUMOR, GROWTH OR OTHER CONDITION? YES NO
9. DO YOU HAVE HIGH OR LOW BLOOD PRESSURE? YES NO
10. DO YOU HAVE ANY INFLAMMATORY DISEASES (ARTHRITIS, RHEUMATISM ETC.)? YES NO
11. DO YOU HAVE ANY ARTIFICIAL JOINTS OR PROTHESIS? YES NO
12. DO YOU HAVE ANY BLOOD DISORDERS (ANEMIA, LEUKEMIA ETC.)? YES NO
13. HAVE YOU EVER BLEED EXCESSIVELY AFTER BEING CUT OR INJURED? YES NO
14. DO YOU HAVE STOMACH, KIDNEY OR LIVER PROBLEMS? YES NO
15. ARE YOU DIABETIC? YES NO
16. DO YOU HAVE ASTHMA? YES NO
17. DO YOU HAVE EPILEPSY OR SEIZURE DISORDERS? YES NO
18. DO YOU HAVE TUBERCULOSIS? YES NO
19. ARE YOU PREGNANT OR SUSPECT YOU MIGHT BE? YES NO
20. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE? YES NO
    IF SO, PLEASE EXPLAIN. _____
    _____
21. IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH THAT WE HAVE NOT COVERED ON THIS FORM? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNATURE _____ DATE _____

RELATIONSHIP (IF NOT PATIENT) _____

MEDICAL ALERT

MEDICAL HISTORY

EXPRESS\DENHIST.EPD

PATIENT NAME:_____
LAST FIRST M.I.

Purpose of initial visit:_____
Are you aware of a problem?_____
How long since your last dental visit?_____
What was done at that time?_____
Previous dentist's name:_____ Location:_____

Date of Birth
/ /

PLEASE CIRCLE THE APPROPRIATE ANSWER

NO Yes Have you made regular visits?
How often?_____
NO Yes Have X-Rays been taken in the last two years?
NO Yes Do you have all your teeth (except wisdom teeth)?
NO Yes If no, have missing teeth been replaced?
NO Yes Are you happy with the replacement?
If no, please explain._____
YES No Would you like to know about permanent replacements?
YES No Do you clench or grind your teeth?
YES No Does your jaw click or pop?
YES No Have you experienced pain or soreness around your ear or the muscles of your face?
YES No Does food get caught between your teeth on a regular basis?
YES No Are any of your teeth sensitive to hot?
YES No Cold?
YES No Sweets?
YES No Pressure?
YES No Do your gums bleed or hurt?
If yes when?_____
NO Yes Do you use dental floss?
NO Yes On a daily basis?
YES No Have you ever had gum treatment or surgery?
What type?_____
What areas?_____
When?_____
NO Yes Are you happy with the appearance of your teeth?
YES No Have you experienced any problems or complications with previous dental treatment?
If yes, what?_____
YES No Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
If yes, what?_____
YES No Do you prefer dental treatment WITHOUT a local anesthetic (novocaine, xylocaine, carbocaine, etc.)?
YES No Have you had dental treatment using nitrous oxide (laughing gas)?
YES No Do you wish to try nitrous oxide or would you like to use it again?
YES No Do you have any questions or concerns?

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT SIGNATURE _____

RELATIONSHIP (If not patient)_____ **DATE:** _____

DENTAL ALERT

DENTAL HISTORY

EXPRESS\REGIST EPD

PATIENT'S NAME_____
IF CHILD, PARENT'S NAME_____
MINOR ____ SINGLE ____ MARRIED ____
SEPARATED ____DIVORCED ___ WIDOWED ___
HOME ADDRESS_____

CITY_____ STATE ___ ZIP _____

SPOUSE'S NAME_____

DATE OF BIRTH__/___/____ SOCIAL SECURITY # ____ – __ – _____

BY WHAT NAME DO YOU WISH TO BE ADDRESSED?_____

HOME TELEPHONE _____ BUSINESS TELEPHONE_____
PATIENT/PARENT EMPLOYER_____
PRESENT POSITION_____ HOW LONG_____
BUSINESS CITY_____ STATE ___ ZIP _____

SPOUSE EMPLOYER_____
SPOUSE SOCIAL SECURITY # _____ – ___ – _____
SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____
WHOM MAY WE THANK FOR THIS REFERAL?_____

DENTAL INSURANCE - PRIMARY COVERAGE

EMPLOYEE NAME_____
EMPLOYEE DATE OF BIRTH_____
EMPLOYER_____
OF YEARS EMPLOYED _____
INSURANCE COMPANY NAME _____
ADDRESS_____
_____
_____
TELEPHONE (_____)_____
PROGRAM OR POLICY # _____
UNION LOCAL OR GROUP # _____
SOCIAL SECURITY # _____ – ____ – _____

DENTAL INSURANCE - SECONDARY COVERAGE

EMPLOYEE NAME_____
EMPLOYEE DATE OF BIRTH_____
EMPLOYER_____
OF YEARS EMPLOYED _____
INSURANCE COMPANY NAME _____
ADDRESS_____
_____
_____
TELEPHONE (_____)_____
PROGRAM OR POLICY # _____
UNION LOCAL OR GROUP # _____
SOCIAL SECURITY # _____ – ____ – _____

I authorize Richard E. Robinson D.D.S. to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I hereby authorize payment of insurance benefits directly to Richard E. Robinson D.D.S. for benefits due me.

I understand that I am ultimately responsible for all expenses related to the dental treatment.

MEDICAL / DENTAL ALERT

PATIENT SIGNATURE_____

RELATIONSHIP (If not patient)_____ **DATE:** _____

REGISTRATION

EXPRESS\SIGNATUR.EPD

PATIENTS NAME: _____

Last First Middle Inital

*I hereby authorize payment directly to **RICHARD E. ROBINSON, D.D.S.** for the dental benefits otherwise payable to me.*

SIGNATURE of *insured* person: _____

Date: _____

RICHARD E. ROBINSON, D.D.S. is authorized to provide any insurance company(s), claim administrator(s) and or consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claim benefits.

This authorization is valid for the term of the policy or contract, in force on this date only, or for two years whichever is shorter.

I acknowledge I have the right to a copy of this authorization upon request and agree that the photographic reproduction or copy of this authorization is as valid as the original.

_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

SIGNATURE ON FILE