ROBSON FAMILY DENTISTRY

240 E SANDUSKY AVE
BELLEFONTAINE, OH 43311
(937)599-6115
frontdesk@robsonfamilydentistry.com

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Address: _____ (House/Apt. Number/Street) _____ (City) _____ (State) _____ (Zip Code)

Status	Birth Date (mm/dd/yyyy)	Home Phone:
☐ Single		Cell Phone:
☐ Married	Social Security Number	Work Phone:
☐ Child		Email:

Patient Employer	Employer Phone Number

PERSON RESPONSIBLE FOR BILL	RELATIONSHIP TO PATIENT	SSN: DOB(mm/dd/yyy)

ADDRESS AND PHONE # FOR RESPONSIBLE PARTY (if different from patient)

INSURANCE INFORMATION

PRIMARY Policy Holder's Full Name		Relationship to Patient
Policy Holder's SSN	DOB (mm/dd/yyy)	Policy Holder Address (if different than patient)
Insurance Company Name		
Policy Holder's Employer		Employer Phone Number

SECONDARY Policy Holder's Full Name		Relationship to Patient
Policy Holder's SSN	DOB (mm/dd/yyy)	Policy Holder Address (if different than patient)
Insurance Company Name		
Policy Holder's Employer		Employer Phone Number

GETTING TO KNOW YOU

Is another member of your immediate family (living at same address) a patient in our practice? If yes, whom?	
Whom may we thank for referring you?	
Who to contact for an emergency:	Phone Number:

More questions on Reverse ➡

HIPAA ACKNOWLEDGMENT AND CONTACT RELEASE

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I am providing my written permission for Robson Family Dentistry to speak to, leave messages at, any of the following numbers regarding my dental appointments or treatment:

	Contact 1	Contact 2	Contact 3	Contact 4
Name				
Phone Number				
Relation				

CONSENT FOR INTERNET COMMUNICATIONS

I understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload, and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED, OR RECEIVED WSING THE SITE OR SERVICES.

FINANCIAL AND ATTENDANCE POLICY

Payment for services rendered is expected to be made at the time of the appointment. Any exceptions to this must be agreed upon prior to your appointment. We accept cash, check, credit card (Visa, MasterCard, Discover) and CareCredit. We Understand that sometimes things happen to keep you from making your appointment. When these issues arise, please let us know as soon as possible. We generally require 24 hour advance notice. If you miss an appointment without advance notice, we will enact the following: 1st missed appointment – no action will be taken. 2nd missed appointment – you will be charged a $50 fee This WILL NOT be covered by insurance. 3rd missed appointment – You will be charged a $50 fee and potentially be dismissed from the practice. The $50 fee must be paid before rescheduling your appointment. If you are late by 15 minutes or more, we reserve the right to reschedule your appointment. Waiver of any of these penalties is at the discretion of Robson Family Dentistry.

☐ By checking this box I acknowledge receipt of the HIPPA policy and will abide by the terms

☐ By checking this box I acknowledge receipt of the internet communications policy and will abide by the terms

☐ By checking this box I acknowledge receipt of the financial and attendance policy and will abide by the terms

Name of patient, parent, or guardian completing this form – relationship to patient if other than "self"

_____

Signature:_____ **Response Date:**_____