Robson Family Dentistry LLC
240 E SANDUSKY AVE
Bellefontaine, OH 43311
(937)599-6115
jonathon@robsonfamilydentistry.com

Welcome to Robson Family Dentistry!

Chart #. _____
FOR OFFICE USE ONLY

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

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

I prefer to be contact by

☐ Cell Phone ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

_____

In an emergency, who should be notified? Please enter name, phone number and relationship below

_____

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Employer Name

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ _____ _____

City State Zip Code

Insurance Subscriber and/or Parent/Guardian Information

This ONLY needs to be filled out if the insurance subscriber is other than the patient AND/OR you are the parent/guardian of the patient

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ _____ _____ _____

Last First MI Preferred Name

Title: _____ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Mr/Ms/Mrs/etc

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ _____ _____ _____ _____ _____

Home Work Ext Mobile Fax Other

Address: _____ _____

_____ _____ _____

City State Zip Code

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Primary Dental Insurance

Name of Insured: Last First MI

Insured's Birth Date: ID #. Group #.

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Insurance Authorization

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Do you have secondary dental insurance?

◯ Yes ◯ No

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Dental Information

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist Name and Phone Number

Approximate date of most recent dental exam and/or dental x-rays

I routinely see a dentist every

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

What is your immediate concern about your dental health?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/Have braces or orthodontic treatment
- ☐ Experiences dry mouth
- ☐ Sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Whitened or bleached your teeth
- ☐ Experienced popping and/or clicking of your jaw joint
- ☐ Difficulty chewing
- ☐ Clenching or grinding of teeth

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- [ ] Currently or previously wore a bite appliance
- [ ] Gums bleed when brushing or flossing
- [ ] Diagnosed and/or treated for gum disease
- [ ] Bone loss around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] Experienced gum recession
- [ ] Teeth become loose on their own (without injury)
- [ ] Experienced a burning sensation in your mouth
- [ ] Snores or wakes up frequently during the night

If any of the checked boxes need further explanation, please describe:

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Financial and Attendance Policy

Financial 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, or credit card (Visa, Mastercard, Discover).

Attendance Policy
We understand that sometimes things happen to keep you from making your appointment. When these issues come up, please let us know as soon as possible that you won't be able to make it. We generally need 24 hours in advance notice to make sure we can fill your spot. If you miss an appointment without notifying us, we will enact the following:
First Missed Appointment- No action will be taken. You may be informed of potential action if you miss again
Second Missed Appointment- You will be charged a $50 fee. This WILL NOT be covered by insurance
Third Missed Appointment- You will be charged a $50 fee or potentially be dismissed from our practice
The $50 fee must be paid PRIOR to being seen by the dentists. If it is not paid, your appointment may be cancelled and treated as a third missed appointment.

If you are late to an appointment by 15 minutes or more, we reserve the right to reschedule your appointment for another day. We will try to still fit you in if we can, but we try to run as efficiently as possible for all of our patients' convenience, and we can't delay everyone else's appointment.

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.

HIPAA Acknowledgment

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 authorize this dental practice to release any financial or dental information to the following person(s) listed below:

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

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Consent for Internet Communications

I also 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 web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

* ☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

* ☐ By checking this box and entering my name below, I agree that everything in this form is true to the best of my knowledge. This is my official signature.

Entering my name here acts as my official signature

*

Today's Date

*

Response Date: 10/11/2016