ROBISON DENTAL GROUP

Whom May We Thank For Referring you? _____

I. Patient: Male ☐

Patient Name _____ Female ☐ Date _____

Address _____ Birthdate _____

City/State/Zip _____ Age _____

Previous Address (if less than 6 months at present address) _____

Home Phone _____ Cell Phone _____ Business Phone _____

E-mail Address _____ Social Security # _____

Employer _____

Marital Status ☐ Single ☐ Married ☐ Head of Household

If Married:

Spouse's Name _____ Social Security # _____

Spouse's Employer _____ Business Phone _____

Employer Address _____

Have any family members been seen in our office? _____

IN CASE OF AN EMERGENCY CONTACT: _____

Relation _____ Address _____ Phone _____

Name, address & phone number of a personal friend _____

II. Dental Insurance Companies:

Primary Insurance Company _____

Insured Name _____ Insured Date of Birth _____

Insured Address (if different than above) _____

Insurance Company Phone # _____ SS/ID # _____ Group # _____

Employer Name _____

Secondary Insurance Company _____

Insured Name _____ Insured Date of Birth _____

Insured Address (if different than above) _____

Insurance Company Phone # _____ SS/ID # _____ Group # _____

Employer Name _____

III. Person Responsible for Account:

Name (if person is different from above patient- then fill in below) _____

Address _____

City/State/Zip _____

Social Security # _____ Birthdate _____

Home Phone _____ Work Phone _____

Employer _____ Employer Address _____

IV. Medical History: Do you have, or have you had, any of the following?

	Yes	No
AIDS/HIV Positive		
Alzheimer's Disease		
Anaphylaxis		
Anemia		
Angina		
Arthritis/ Gout		
Artificial Heart Valve		
Artificial Joint		
Asthma		
Blood Disease		
Blood Transfusion		
Breathing Problem		
Bruise Easily		
Cancer		
Chemotherapy		
Chest Pains		
Cold Sores/ Fever Blisters		
Congenital Heart Disorder		
Convulsions		
Cortisone Medicine		
Diabetes		
Drug Addiction		
Easily Winded		
Emphysema		
Epilepsy or Seizures		
Excessive Bleeding		
Excessive Thirst		
Fainting Spells/ Dizziness		
Frequent Cough		
Frequent Diarrhea		
Frequent Headaches		
Genital Herpes		
Glaucoma		
Hay Fever		
Heart Attack/ Failure		
Heart Murmur		
Heart Pacemaker		
Heart Palpitations		
Heart Trouble/ Disease		
Hemophilia		
Hepatitis A		
Hepatitis B		
Hepatitis C		
Herpes		
High Blood Pressure		
High Cholesterol		
Hives or Rash		
Hypoglycemia		
Irregular Heartbeat		
Kidney Problems		
Leukemia		
Liver Disease		
Low Blood Pressure		
Lung Disease		
Mitral Valve Prolapse		
Osteoporosis		
Pain in Jaw Joints		
Parathyroid Disease		
Parkinson's Disease		
Psychiatric Care		
Radiation Treatments		
Recent Weight Loss		
Renal Dialysis		
Rheumatic Fever		
Rheumatism		
Scarlet Fever		
Shingles		
Sickle Cell Disease		
Sinus Trouble		
Spina Bifida		
Stomach/Intestinal Disease		
Stroke		
Swelling of Limbs		
Thyroid Disease		
Tonsillitis		
Tuberculosis		
Tumors or Growths		
Turrets		
Ulcers		
Venereal Disease		
Yellow Jaundice		

Are you allergic to any of the following?

	Yes	No
Aspirin		
Local Anesthetics		
Latex		
Penicillin		
Acrylic		
Sulfa Drugs		
Codeine		
Metal		
Other:		

Woman are you:

	Yes	No
Pregnant/trying to get pregnant?		
Taking oral Contraceptives?		
Nursing?		

Are you under a physician's care now? _____ If yes who is your doctor? _____

Have you been hospitalized or had a major operation? _____ If yes please explain _____

Have you ever had a serious head or neck injury? _____ If yes please explain _____

Are you taking any medications, pills, or drugs? _____ If yes please list medication and reason for:

_____

_____

_____

Have you or are you taking Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _____

Are you on a special diet? _____ **Do you use tobacco?** _____ **Do you use controlled substances?** _____

Do you want whiter teeth? _____**Yes** _____**No**

V. If I hereby grant permission for dental treatment to be performed on this minor and will assume all responsibilities connected with such treatment.

VI. I understand that I **Should Not** mix prescribed medications with alcoholic beverages and understand that I **Should Not** operate any vehicle or hazardous device when taking a narcotic or sedative medication. Since a change of medical condition or medication can affect dental treatment, I understand the importance of and agree to notify Dr. Robison of any changes at any subsequent appointment.

VII. I hereby authorize payment directly to Robison Dental Group. I understand that I am responsible for all costs regardless of insurance payment.

By signing below I Have read and understand the above and agree to the terms therein.

Signature _____ Date _____

ROBISON DENTAL GROUP

Insurance, Financial & HIPAA Agreement

Thank you for choosing Robison Dental Group as your dental care provider. We are committed to providing you with caring , expert, professional care that meets your individual needs. This financial policy is an important part of your dental care. We accept most PPO/indemnity insurance plans. Please note that your insurance is a contract between you and your insurance company, not between our office and your insurance company.

It is your responsibility to be aware of your benefits:

1. **Insurance:** We will bill your insurance company for any service rendered as a courtesy. In order to bill you must present your insurance card so that we can have a record on file. **If your insurance company or benefits change and you have a pending appointment, please call our office at least 48 hours prior to that appointment with your new insurance information.**
   I understand that if there is a balance after my insurance has paid that I am financially responsible.
2. **Co-payments & Deductibles :** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Patients with deductibles that have not been met will be required to pay the assigned deductible with the co-payment at the time of service.
3. **Non-Covered Services:** All insurance plans are not the same and they do not always cover the same services. Please be aware that some of the services you receive may be determined "not covered" by your insurance plan. You must pay for these services in full at time of service.
4. **Payment:** Payment in full is expected at each visit. Robison Dental Group accepts most major credit cards, debit cards, checks and cash. **There will be a $35.00 fee for any checks returned to us from your bank. After 2 returned checks, you will be required to pay cash only.**
5. **Non-Payment:** If your account is over 30 days past due and there has been no communication with our billing department, there will be a finance charge of 1 1/2% per month on the unpaid balance (annual rate of 18%) with a minimum charge of $1.00 per month. If there are legal fees and costs reasonably incurred in connection therewith, you are liable to pay for all fees and costs. Interest not paid when due shall be added to and become part of the principal.
6. **No-shows:** We understand that situations may arise that require you to not be here for your appointment. However, by not showing for your appointment it not only affects you, but affects many other people. **There may be a $42 fee for any missed appointments or late changes in your appointment.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to ask you:

Do we have permission to discuss your care with anyone other than yourself: YES NO

Please specify:

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

Do we have permission to leave detailed message on your voicemail? YES NO
I have received a copy of Robison Dental Group's HIPPA Policy: YES NO

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates & payment terms of this office. In the event I am entitled to dental insurance or other benefits relating to my dental condition & they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office may release record of my treatment to my insurance company or other third parties responsible for payment of my dental charges.

Patient/Guardian Signature: _____ **Date:** _____

VIVOS®

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosed with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = (your weight in pounds X 703)

_____

(your height in inches X your height in inches)