

# Robison Family Dental

## Brandon J. Robison, DMD

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## Welcome

We know there are many places to choose for dental care. We are honored that today, you have given us the opportunity to earn your trust as an oral health care provider. We value our patients, and would love to personally thank anyone that recommended our office. In the space below, please share with us how you learn about our office.

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## Patient Information

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

At times, our office may need to communicate with you quickly.

Please provide us with the following phone numbers.

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone \_\_\_\_\_  
Spouse's Name \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

## Dental Insurance Information

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Name of Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

### Secondary Insurance

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Name of Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

# Health History

Have there been any problems in your general health within the past five years?(Serious illness, surgery, etc.)

Yes  No If yes, please explain\_\_\_\_\_

Have you had any form of cancer? Yes  No If yes, which type?\_\_\_\_\_

Are you currently under a physician's care? Yes  No If yes, please explain\_\_\_\_\_

Physician's Name:\_\_\_\_\_ Phone #:\_\_\_\_\_

Please list any medication you are currently taking (vitamins, drugs, pain pills, herbs etc.)

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Have you ever tested positive for HIV? Yes No If yes, what date?\_\_\_\_\_

Have you ever been told that you need an antibiotic before dental treatment? Yes No

## DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

### Yes No

- Rheumatic Fever, Rheumatic Heart Disease
- Stroke
- Pain in Chest, Shortness of Breath
- Blood Disorders, Anemia
- Positive Test for Venereal Disease
- Cold Sores
- Kidney Disease
- Radiation Treatment
- Hepatitis A,B,C
- Organ Transplant
- Tuberculosis

### Yes No

- Heart Murmur, Mitral Valve Prolapse
- Heart Trouble, Heart Attack
- High Blood Pressure
- Diabetes
- Asthma
- Low Blood Pressure
- Bruise Easily or Abnormal Bleeding
- Fainting or Seizures
- Jaundice or Liver Disease
- Artificial Joint Replacement
- Do You or Have Smoked

## FOR WOMEN ONLY

Are You Pregnant?

Taking birth control pills?

## ARE YOU SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING?

### Yes No

- Penicillin
- Aspirin
- Latex
- Tylenol

### Yes No

- Erythromycin
- Pain Pills
- Vinyl
- Ibuprofen

### Yes No

- Codeine
- Metals
- Sulfa
- Acrylic

Please listed any condition not mentioned above

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Have you ever taken: Actonel, Boniva, Fosamax, Skelid or Didronel? Yes No

# Dental History

Date of Last Dental Visit \_\_\_\_\_ Previous Dentist \_\_\_\_\_

Does Dental Treatment Make You Nervous?  Yes  No If yes, what part of dentistry makes you uneasy?

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How can we make your visit comfortable? \_\_\_\_\_

Do you have any of the following?

<b>MOUTH</b>	<b>Yes</b>	<b>No</b>	<b>TEETH</b>	<b>Yes</b>	<b>No</b>
Bleeding or sore gums?	<input type="checkbox"/>	<input type="checkbox"/>	Loose Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Temperature sensitive teeth	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of lip/tongue	<input type="checkbox"/>	<input type="checkbox"/>	Pain while biting	<input type="checkbox"/>	<input type="checkbox"/>
Discolored lip, cheek, tongue	<input type="checkbox"/>	<input type="checkbox"/>	Discolored teeth	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Cracked/chipped teeth	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had a reaction to dental anesthetic?  Yes  No

Are you currently in pain?  Yes  No If yes, please describe \_\_\_\_\_

Do you have any missing teeth?  Yes  No If yes, is it important to have them replaced?  Yes  No

Are you aware of any popping or clicking in your jaw?  Yes  No

Do you have frequent headaches or chronic neck pain?  Yes  No

# Cosmetic Dentistry

Is there anything about your smile that you would change? \_\_\_\_\_

Have you ever whitened your teeth?  Yes  No If no, are you interesting in learning about whitening?  Yes  No

I, the undersigned, verify that the above information is correct to the best of my knowledge.

Patient/ Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_