Robison Family Dental

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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.

_____

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.)
_____

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		Yes	No	
□	□	Rheumatic Fever, Rheumatic Heart Disease	□	□	Heart Murmur, Mitral Valve Prolapse
□	□	Stroke	□	□	Heart Trouble, Heart Attack
□	□	Pain in Chest, Shortness of Breath	□	□	High Blood Pressure
□	□	Blood Disorders, Anemia	□	□	Diabetes
□	□	Positive Test for Venereal Disease	□	□	Asthma
□	□	Cold Sores	□	□	Low Blood Pressure
□	□	Kidney Disease	□	□	Bruise Easily or Abnormal Bleeding
□	□	Radiation Treatment	□	□	Fainting or Seizures
□	□	Hepatitis A,B,C	□	□	Jaundice or Liver Disease
□	□	Organ Transplant	□	□	Artificial Joint Replacement
□	□	Tuberculosis	□	□	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		Yes	No		Yes	No	
□	□	Penicillin	□	□	Erythromycin	□	□	Codeine
□	□	Aspirin	□	□	Pain Pills	□	□	Metals
□	□	Latex	□	□	Vinyl	□	□	Sulfa
□	□	Tylenol	□	□	Ibuprofen	□	□	Acrylic

Please listed any condition not mentioned above
_____

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?

_____

How can we make your visit comfortable? _____

Do you have any of the following?

MOUTH	**Yes**	**No**	**TEETH**	**Yes**	**No**
Bleeding or sore gums?	□	□	Loose Teeth	□	□
Unpleasant taste/bad breath	□	□	Temperature sensitive teeth	□	□
Swelling of lip/tongue	□	□	Pain while biting	□	□
Discolored lip, cheek, tongue	□	□	Discolored teeth	□	□
Dry mouth	□	□	Cracked/chipped teeth	□	□

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_____