COMFORT MENU

We would like to make your visit as enjoyable and comfortable as possible!
Please choose any of the following Items:

__ BLANKET

__COFFEE

__ NECK REST

__WATER

__ PILLOW

__ TEA

__ WARM NECK WRAP

__ IPAD

__ DISPOSABLE EAR PLUGS

__ WARM, MOIST TOWELETTE

__ NINTENDO DS

__ EYE MASK

__ HEADSET

__ SUNGLASSES

__ CHAP STICK

It is our pleasure and privilege to have you as our patient. Please remember that our best referrals are from patients like you! Send your family and friends our way!!

ROBINSON DENTAL

Tell us about yourself…

Date:_____/_____/______

Patient Name: ____
Last, First MI Preferred/Nick Name

Date of Birth: _________/_________/_____________ Social Security # *(for insurance purposes)*: ________________________

Sex: ☐ Male ☐ Female

Phone *(Home)*: ____________________________________ *(Cell)*: ______________________________________

Email: ____

Address: ____
Street Apartment #

____
City State Zip Code

Employer Name: ____ Phone: ____________________________________

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Married: ________________________

Spouse Name: ____
Last, First MI

Date of Birth: _________/_________/_____________ Social Security # *(for insurance purposes)*: ______________________

Do you currently have dental Insurance? ☐ YES ☐ NO **Do you have a secondary policy?** ☐ YES ☐ NO

IF NO:

I am interested in learning more about:

- ☐ Robinson Dental's In-Office Savings Plan
- ☐ Care Credit Financing
- ☐ NONE OF THE ABOVE, I will be paying by cash, check, or VISA/Mastercard

IF YES:

Insurance Company: ______________________________________

Primary Subscriber: ______________________________________

Employer's Name: ____

ID # or Subscriber SSN: ____________________________________

Primary Subscriber Date of Birth: _____________________

HIPAA Privacy Patient Consent:

- ❑ I have read a copy of this office's Notice of Privacy Practices.
- ❑ I have chosen not to read a copy, but I am aware of this office's privacy practices.

With whom may we discuss your dental health and/or account with? ______________________________

Relationship to Patient: ______________________________

**Without this written consent, we cannot discuss your treatment or account with anyone other than you.*

How did you hear about our office?

☐ Family/Friend: ______________________________ ☐ I live in town/Drive by your office ☐ Google/Internet search

☐ Event: __________ ☐ I received your mail What made you decide to come in? __________________

Our Responsibility... ...

Providing the highest quality dental care involves keeping you informed so you can make good decisions about your dental health. We perform a wide variety of dental procedures here and we do realize that things can sometimes get a little confusing. We want you to know that you have a right to ask questions about anything you don't understand. We will be pleased and frankly, delighted, to answer your questions.

As a courtesy, we will gladly file your insurance claim to your insurance company; however, your insurance contract is between you, your employer and the insurance company. If you have any concerns or disputes on what the insurance company covers, we ask that you contact them directly as we cannot alter you're agreed upon contract.

Please take note...

- A charge of $25.00 will be assessed for all returned checks.
- We reserve the right to charge $30 for appointments cancelled or broken without 24 hours advance notice.
- Balances over *90 days old* will be referred to **small claims court**. In the event you are sent to court, there will be a 50% charge added to your account and you will be responsible for all court fees.

I certify that I have read and understand this form as well as my financial responsibilities, and that I have the right to ask questions before agreeing to any procedure(s). I understand further that I have the right to be provided with answers to questions that may arise during the course of my treatment. I am aware that the practice of dentistry is not an exact science and I acknowledge that no written or oral representations, warranties or guarantees have been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers, demonstrations and/or presentations certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

______________________________________ ____________________

PRINT Name of Patient, Parent or Guardian Relationship to Patient

______________________________________ ____________________

Signature of Patient, Parent or Guardian Date

Family caring for family…

Dr. Elizabeth Robinson, DDS
Dr. Scott Robinson, DDS
Dr. Malavi Patel, DMD
Dr. Derek DeVries, DDS
Dr. Jake Streng, DDS
Dr. Alex Hoelzel, DDS
Dr. Jeff Cartwright DDS
Dr. Steve Feddick DDS

502 W. Randall St.
Coopersville, MI 49404

899 Reno Drive
Wayland, MI 49348

888-WE-C-U-NOW
888-932-8669

Info.robinsondental@gmail.com

**I give my consent to Robinson Dental for treatment of myself. I authorize my insurance benefits to be paid directly to Robinson Dental. I realize that I am responsible to pay non-covered services and/or any co-pay/deductible. Payment is due at the time of services rendered. If for some reason my account is sent to a collection agency or an attorney for non-payment, I agree to pay all collection and court costs, attorney fees, and other costs incurred. I hereby authorize the release of pertinent medical information to insurance carriers for payment purposes. I am aware that it is my obligation to know my insurance company's policies and coverages.

<u>Billing and Insurance:</u> Our professional relationship is with you, and not with any insurance carrier. You are responsible for paying the full cost of treatment when it is rendered unless it is covered by insurance. We accept most major insurance companies and we will submit all authorized claims to the designated insurance carrier, provided we have received all required information. For your convenience, we will request verification of your co-pays and deductible from your insurance carrier. It is your responsibility to confirm your co-pay and deductible, and to make required payments at the time of each appointment (we accept cash, personal check, Visa, MasterCard, Discover and Care Credit). We will charge a $25.00 fee for any returned check. Note that quoted deductibles and co-pays are provided by your insurance carrier as **<u>estimates only, and do not guarantee payment</u> by your insurance carrier. Some services or treatments might not be covered benefits under your insurance plan. You are responsible for payment of any services or treatments not covered by your insurance carrier.

**<u>Missed Appointments:</u> You will not be billed for missed appointments if you give us at least 24 hour notice of cancellation, so that we can schedule another patient. Failure to give a 24 hour notice, or a no call/no show will result in a $30.00 charge.

**<u>Past Due Account</u>: Accounts not paid within 30 days are considered past due. You are responsible for payment of any costs we incur in collecting past due accounts (such as collection agency and attorneys fee). Effective June 1st, 2015, all outstanding balances older than 90 days will be subject to a 6% monthly finance charge.

I understand and agree to the terms of this document, I authorize Robinson Dental to bill my insurer(s) for all services rendered and I authorize my insurer(s) to make payment directly to Robinson Dental.

This authorization will be effective for a period of one year from the date of signing.

X____ **Date**______/_____/__________

Signature of Responsible Party **(must be over 18 years old)**

DENTAL HISTORY

Name________________________________ Nickname______________________________ Age_________
Referred by___________________________How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _______________________________How long have you been a patient?___________Months/Years
Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

		YES	NO
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] ____________________	☐	☐
2.	Have you had an unfavorable dental experience? ____________________	☐	☐
3.	Have you ever had complications from past dental treatment? ____________________	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic? ____________________	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted? ____________________	☐	☐
6.	Have you had any teeth removed?____________________	☐	☐

GUM AND BONE

		YES	NO
7.	Do your gums bleed or are they painful when brushing or flossing? ____________________	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? ____________________	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth? ____________________	☐	☐
10.	Is there anyone with a history of periodontal disease in your family? ____________________	☐	☐
11.	Have you ever experienced gum recession? ____________________	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? __________	☐	☐
13.	Have you experienced a burning sensation in your mouth? ____________________	☐	☐

TOOTH STRUCTURE

		YES	NO
14.	Have you had any cavities within the past 3 years? ____________________	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ____________________	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ____________________	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ____________________	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line? ____________________	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ____________________	☐	☐
20.	Do you frequently get food caught between any teeth? ____________________	☐	☐

BITE AND JAW JOINT

		YES	NO
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ____________________	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together? ____________________	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? __________	☐	☐
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? ____________________	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped? ____________________	☐	☐
26.	Are your teeth developing spaces or becoming more loose? ____________________	☐	☐
27.	Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? ____________________	☐	☐
28.	Do you place your tongue between your teeth or rest your teeth against your tongue? ____________________	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ____________________	☐	☐
30.	Do you clench your teeth in the daytime or make them sore? ____________________	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? __________	☐	☐
32.	Do you wear or have you ever worn a bite appliance? ____________________	☐	☐

SMILE CHARACTERISTICS

		YES	NO
33.	Is there anything about the appearance of your teeth that you would like to change? ____________________	☐	☐
34.	Have you ever whitened (bleached) your teeth? ____________________	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth? ____________________	☐	☐
36.	Have you been disappointed with the appearance of previous dental work? ____________________	☐	☐

Patient's Signature ____ Date____________________

Doctor's Signature ____ Date ____________________

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MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury ______	☐	☐
2.	an allergic reaction to ☐ aspirin, ibuprofen, acetaminophen, codeine ☐ penicillin ☐ erythromycin ☐ tetracycline ☐ sulfa ☐ local anesthetic ☐ fluoride ☐ metals (nickel, gold, silver, ________) ☐ latex ☐ other ______		
3.	heart problems, or cardiac stent within the last six months ___	☐	☐
4.	history of infective endocarditis ______	☐	☐
5.	artificial heart valve, repaired heart defect (PFO) ______	☐	☐
6.	pacemaker or implantable defibrillator ______	☐	☐
7.	orthopedic implant (joint replacement) ______	☐	☐
8.	rheumatic or scarlet fever ______	☐	☐
9.	high or low blood pressure ______	☐	☐
10.	a stroke (taking blood thinners) ______	☐	☐
11.	anemia or other blood disorder ______	☐	☐
12.	prolonged bleeding due to a slight cut (INR > 3.5) ______	☐	☐
13.	emphysema, shortness of breath, sarcoidosis ______	☐	☐
14.	tuberculosis, measles, chicken pox ______	☐	☐
15.	asthma ______	☐	☐
16.	breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17.	kidney disease ______	☐	☐
18.	liver disease ______	☐	☐
19.	jaundice ______	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
21.	hormone deficiency ______	☐	☐
22.	high cholesterol or taking statin drugs ______	☐	☐
23.	diabetes (HbA1c = ______) ______	☐	☐
24.	stomach or duodenal ulcer ______	☐	☐
25.	digestive disorders (i.e. celiac disease, gastric reflux) ______	☐	☐
26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27.	arthritis ______	☐	☐
28.	autoimmune disease ______ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29.	glaucoma ______	☐	☐
30.	contact lenses ______	☐	☐
31.	head or neck injuries ______	☐	☐
32.	epilepsy, convulsions (seizures) ______	☐	☐
33.	neurologic disorders (ADD/ADHD, prion disease) ______	☐	☐
34.	viral infections and cold sores ______	☐	☐
35.	any lumps or swelling in the mouth ______	☐	☐
36.	hives, skin rash, hay fever ______	☐	☐
37.	STI / STD / HPV ______	☐	☐
38.	hepatitis (type ___) ______	☐	☐
39.	HIV / AIDS ______	☐	☐
40.	tumor, abnormal growth ______	☐	☐
41.	radiation therapy ______	☐	☐
42.	chemotherapy, immunosuppressive medication ______	☐	☐
43.	emotional difficulties ______	☐	☐
44.	psychiatric treatment ______	☐	☐
45.	antidepressant medication ______	☐	☐
46.	alcohol / recreational drug use ______	☐	☐

ARE YOU:

		YES	NO
47.	presently being treated for any other illness ______	☐	☐
48.	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______	☐	☐
49.	taking medication for weight management ______	☐	☐
50.	taking dietary supplements ______	☐	☐
51.	often exhausted or fatigued ______	☐	☐
52.	experiencing frequent headaches ______	☐	☐
53.	a smoker, smoked previously or use smokeless tobacco _	☐	☐
54.	considered a touchy / sensitive person ______	☐	☐
55.	often unhappy or depressed ______	☐	☐
56.	FEMALE - taking birth control pills ______	☐	☐
57.	FEMALE - pregnant ______	☐	☐
58.	MALE - prostate disorders ______	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

ASA ______ (1-6) ○ ○ ○

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