# Tell us about yourself…

Date:______/______/______

Patient Name: ________________________________________________________________
Last First MI Preferred/Nickname

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

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Spouse Name: ____________________________________________________________
Last First MI

Date of Birth: _______/_______/_________ Social Security # *(for insurance purposes)*: ____________________

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**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
______________________________

⏭ Care Credit Financing
______________________________

⏭ NONE OF THE ABOVE, I will be paying by cash, check, or VISA/Mastercard

**IF YES:**

Insurance Company: _____________________________

Plan 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.*

**Who may we THANK for sending YOU our way?**

NAME**:**_______________________________________

* We would love to thank them and get them entered into our awesome giveaway.

☐ Facebook ☐ Mail ☐ Event:______________________________
☐ Google ☐ TV ☐ Employer:___________________________
☐ Radio

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**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 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 your agreed contract.

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**Please take note…**

- A charge of $25 will be assessed for all returned checks.
- We reserve the right to charge $30 for appointments canceled 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.

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I certify that I have read and understood 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 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. Meghan Moore, DDS*
*Dr. Michael Lilly, DMD*
*Dr. Claire Kittaka, DMD*
*Dr. Alex Keefer, DDS*
*Dr. Aubrey Beeler, DDS*

502 W. Randall St.
Coopersville, MI 49404

899 Reno Drive
Wayland, MI 49348

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

coopersville@robinsondental.org
wayland@robinsondental.org

**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 copay/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.

****Billing and Insurance:** 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 copays and deductible from your insurance carrier. It is your responsibility to confirm your copay 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 are copays are provided by your insurance carrier as **estimates only, and do not guarantee payment** 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.

****Missed Appointments:** You will not be billed for missed appointments if you give us at least 24 hours 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.

****Past Due Account:** 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 attorney fees). 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)*

Robinson DENTAL

Patient Name: ______________________________________ Date of Birth: _____ / ______ /_______
LAST FIRST MI

**Dental Information:**

Reason for dental visit today: _____________________________________________________

Date of last dental visit: ___________________ Name of Dentist: __________________________

Do you have any fears or anxieties related to previous dental experience? YES NO

If YES, please explain? ____________________________________________________________

Are you currently or have you ever experienced any of the following:

- ❏ Tenderness
- ❏ Sore areas in mouth
- ❏ Bleeding gums
- ❏ Pain in or near ears
- ❏ Bad breath
- ❏ Sensitivity to hot, cold, or sweets

On a scale of 1-10, circle your pain level. No Pain 1 2 3 4 5 6 7 8 9 10 High

Have you had any serious trouble associated with any previous dental treatment? YES NO

If YES, please explain: ___________________________________________________________

Have you ever had trouble getting numb or had reactions to local anesthetic? YES NO

Do you have any problems with your jaw joint? (pain or sounds) YES NO

Do you clench your teeth in the daytime or make them sore? YES NO

Do you wear or have you ever worn a bite appliance? YES NO

Is there anything about the appearance of your teeth that you would like to change? YES NO

Patient Signature ________________________________________ Date ____________________

Doctor's Signature ______________________________________ Date ____________________

Patient Name: ______________________________________________ Nickname: ______________________

LAST FIRST MI

**Medical Information:**

Allergies:

- ❏ Asprin, Motrin (ibuprofen)
- ❏ Tylenol (Acetaminophen)
- ❏ Codeine or other Narcotic
- ❏ Iodine
- ❏ Penicillin or other antibiotic ______________________
- ❏ Latex
- ❏ Local Anesthetics
- ❏ Acrylic
- ❏ Metals
  - ❏ If yes, specify ____________________
- ❏ Other (please list) ________________________________________________________

Medications - please list all medications, including non-prescription medications:

| Name of Medication | Amount/Dosage | Frequency | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Do you have any of the following diseases or conditions?

- ❏ Unexplained Fever
- ❏ Head Injury
- ❏ Epilepsy/Seizures
- ❏ Nervous Disorder
- ❏ Mental Disorder
- ❏ Fainting/Dizzy Spells
- ❏ Stroke
- ❏ Glaucoma
- ❏ Sinus Problems
- ❏ Cold Sores
- ❏ Thyroid Disease
- ❏ Respiratory Problems
- ❏ Asthma
- ❏ Shortness of Breath
- ❏ Tuberculosis
- ❏ Heart Attack/Heart Trouble
- ❏ Angina/Coronary Insufficiency
- ❏ High blood Pressure
- ❏ Chest Pain
- ❏ Damaged or Artificial Heart Valves
- ❏ Congenital Heart Disease
- ❏ Rheumatic Fever
- ❏ Cardiac Pacemaker

- ❑ Ulcers
- ❑ Liver Disease
- ❑ Jaundice
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Kidney Disease
- ❑ Venereal Disease
- ❑ AIDS/HIV
- ❑ Arthritis
- ❑ Cancer/Tumors
- ❑ Diabetes
- ❑ Hypoglycemia
- ❑ Cortisone Injections
- ❑ Blood or Bleeding disorders
- ❑ Blood Transfusion

If answering YES to any conditions or diseases please explain: ____________________________
________________________________________________________________________________



Do you have any other medical problems or concerns? YES NO ________________________

Do you smoke? YES, NO Do you use chewing tobacco? YES NO

Do you currently or have you ever used controlled substances (drugs)? YES NO

Has there been any change in your general health within the past year? YES NO

Are you under the care of a physician? YES NO
If YES, what is the condition being treated? ___________________________________________
Name and number of your physician: ________________________________________________

Have you had a serious illness, operation or been hospitalized in the past 5 years? YES NO
If YES, please explain the operation or illness: _______________________________________
________________________________________________________________________________

Do you have any artificial joints? YES NO

Has a medical doctor ever advised you to take antibiotics before a dental procedure? YES NO
If YES, please specify: ______________________________________________________________

**Women:**

Are you or could you be pregnant? YES NO, When is your due date? ____________________
Are you nursing? YES, NO Are you taking birth control pills? YES NO

Name of person completing this form: _______________________

Relationship to patient: ___________________________

I certify to the best of my knowledge, the questions on this form have been answered accurately. I understand that providing false or incorrect information can be detrimental to my (or patient's) health. I understand it is my responsibility to inform the dental office of any changes in my health or medical history. I will not hold my dentist or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

___________________________________ ___________________________________
PRINT NAME SIGNATURE

DOCTOR'S SIGNATURE ____________________________________________

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice where it is in effect. This Notice takes effect 04/26/2016 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we create and/or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. **For example:**
**Treatment:** We may use or disclose your health information to a physician or other healthcare providers providing treatment to you.
**Payment:** We may use and disclose your health information to obtain payment for the services we provide for you.
**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the compliance or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
**Your Authorization**: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
**To Your Family and Friends:** We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare. Only if you agree that we may do so.
**Persons Involved in Care:** We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for you care or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on circumstances using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.
**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary in the event of a serious threat to your health or safety or the health or safety of others.

**Do you snore and/or have trouble sleeping?**

**Have you ever heard of obstructive sleep apnea?... We are a licensed provider!**

**<u>Please circle all that apply:</u>**

**Obstructive sleep apnea: yes/no**

**Diabetes: yes/no**

**Thyroid problems: yes/no**

**Insomnia: yes/no**

**Depression: yes/no**

**COPD: yes/no**

**Morning headaches: yes/no**

**Restless leg syndrome: yes/no**

**Frequent night time urination: yes/no**

**High blood pressure: yes/no**

**Heart disease: yes/no**

**Stroke: yes/no**

## Epworth Sleepiness Questionnaire

**Use the following scale to choose the most appropriate # for your situation**

**0= Never doze 1= Slight Chance 2= Moderate Chance 3= High Chance**

| | |
|---|---|
| **Sitting and reading** | **0 1 2 3** |
| **Sitting quietly in a public place** | **0 1 2 3** |
| **Watching TV** | **0 1 2 3** |
| **Sitting quietly after lunch without alcohol** | **0 1 2 3** |
| **Laying down to rest in the afternoon** | **0 1 2 3** |
| **Sitting and talking to someone** | **0 1 2 3** |
| | **TOTAL: ________** |

***If your score is 7 or above, you may be at risk for sleep apnea.**