

# ACCOUNT REGISTRATION

Please Print Legibly - Do Not Write in Shaded Areas

Date \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

Last Name	Title Mr/Mrs	First Name	M.I.	Sex	Telephone Numbers Home Office
Address		City	State	Zip Code	Cell#
Employer Name	Employer Address			City	State
Person Who Referred You	I Accept Responsibility For This Account Signature of Responsible Person, Spouse or other Guarantor				Patient SS Number

## SPOUSE INFORMATION

Last Name	Title Mr/Mrs	First Name	M.I.	Sex	Telephone Numbers Home Office
Address		City	State	Zip Code	Birth Date
Employer Name	Employer Address			City	State
					Patient SS Number

## DEPENDENT INFORMATION

Last Name (if same - put "Same")	First Name	MI	Sex	Birth Date	Patient SS Number
1.					
2.					
3.					
4.					

## DENTAL HISTORY

### General Dental Information

1. Previous Dentist \_\_\_\_\_ Period of Treatment \_\_\_\_\_
2. Address \_\_\_\_\_ Phone \_\_\_\_\_
3. Other Dentist \_\_\_\_\_ Specialty \_\_\_\_\_
4. Last Dental Visit \_\_\_\_\_ Last Full-Mouth X-Rays \_\_\_\_\_ Last Complete Dental Exam \_\_\_\_\_
5. What is your immediate dental concern? \_\_\_\_\_
6. Is there a reason you are changing dentists? Yes No If yes, explain \_\_\_\_\_

### Dental Conditions

1. Do you have or have you had any of the following?
 

a. Bleeding, Sore Gums	YES NO	j. Clenching/Grinding	YES NO
b. Unpleasant Taste/Bad Breath	YES NO	k. Sensitive Teeth	YES NO
c. Loose Teeth	YES NO	l. Orthodontic Treatment (Braces)	YES NO
d. Periodontal (Gum) Treatment	YES NO	m. Dentures - Full or Partial	YES NO
e. TMJ Treatment	YES NO	n. Swelling/Tumors	YES NO
f. Clicking/Popping Jaw	YES NO	o. Implants	YES NO

# INSURANCE INFORMATION

RESPONSIBLE PERSON'S INSURANCE INFORMATION			SPOUSE'S INSURANCE INFORMATION		
CARRIER (INSURANCE COMPANY) NAME AND ADDRESS			CARRIER (INSURANCE COMPANY) NAME AND ADDRESS		
<b>WHO IS COVERED?</b> (CIRCLE) Husband Wife Dependents 1 2 3 4	SS Number of Insured	Policy Number	<b>WHO IS COVERED?</b> (CIRCLE) Husband Wife Dependents 1 2 3 4	SS Number of Insured	Policy Number
Employee No. (If Any)	Group Name (If Any)	Group Number (If any)	Employee No. (If Any)	Group Name (If Any)	Group Number (If any)

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents an that I will be bound by this signature as though the undersigned had personally signed the particular claim.

\_\_\_\_\_ Authorized Signature of Covered Person/Employee    Date \_\_\_\_\_  
 I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

\_\_\_\_\_ Authorized Signature of Covered Person/Employee    Date \_\_\_\_\_  
 \_\_\_\_\_ Authorized Signature of Covered Person/Employee    Date \_\_\_\_\_

We are happy to submit your insurance forms at no charge. Please be aware that although insurance benefits are assigned to doctor, responsibility for the account is still between patient and doctor. Predetermination of benefit payable will be done when necessary to prevent misunderstanding between doctor, patient and insurance carrier.

## CONSENT

### Treatment/Authorization & Acknowledgment

The undersigned hereby authorized Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient ) \_\_\_\_\_ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 30 days. In the event of default I (we) agree to pay 35% finance charge in addition to the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection of this note.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Patient, Parent or Agent (must be 18 years or older)

## Privacy Practices

Todd M. Roby D.D.S. P.C.  
 Acknowledgement of Receipt of notice of Privacy Practices

\*You may refuse to sign this acknowledgement\*

I (please print) \_\_\_\_\_, have received a copy of this offices' Notice of Privacy Practices.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

#### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify)

# General Health Information

## Medical History

Please answer all questions as completely as possible.

Who is your general care physician? \_\_\_\_\_ Specialist(s)? \_\_\_\_\_

Have you ever been hospitalized or had a major operation? YES NO Describe \_\_\_\_\_

Have you ever had a serious injury to your head or neck? YES NO Describe \_\_\_\_\_

Are you taking any medications? YES NO Please list \_\_\_\_\_

Do you use tobacco in any form? YES NO

Are you allergic to any medications or substances? YES NO Please list \_\_\_\_\_

Women: circle any of the following which apply: pregnant/trying to get pregnant nursing taking contraceptives hormone replacement therapy

PLEASE CHECK YES OR NO TO ALL OF THE FOLLOWING. \*If you answer yes to any of the starred questions, antibiotic premedication may be required prior to dental treatment.

DO YOU NOW OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS: Fosamax Bonifos Ostac Didronel Boniva Aredia Evista Actonel Forteo Skelid Zometa Fen-Phen

DO YOU NOW OR HAVE YOU EVER HAD:

- | Y                         | N                        | Y                          | N                        | Y                        | N                        | Y                        | N                        |
|---------------------------|--------------------------|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble/Disease     |                          | Mitral Valve Prolapse*     |                          | Hepatitis B or C         |                          | Psychiatric Care         |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur*             |                          | Scarlet Fever              |                          | Osteoporosis             |                          | Alzheimers Disease       |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular Heart Beat      |                          | Lung Disease               |                          | Kidney Problems          |                          | Shortness of Breath      |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Angina/Chest Pain         |                          | Emphysema                  |                          | Thyroid Disease          |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Heart Attack/Failure      |                          | Frequent Cough             |                          | Parathyroid Disease      |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Drug Addiction/Alcoholism |                          | Breathing Problem          |                          | Arthritis/Gout           |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Tattoos                   |                          | Cancer                     |                          | Rheumatism               |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| HIV Positive              |                          | Tuberculosis               |                          | Sickle Cell Disease      |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Yellow Jaundice           |                          | Asthma                     |                          | Cortisone Medication     |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Artificial Heart Valve*   |                          | Bloody Sputum              |                          | Artificial Joint*        |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Rheumatic Fever*          |                          | Blood Vessel Surgery       |                          | Venereal Disease         |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Heart Pacemaker*          |                          | Radiation/X-Ray Treatment* |                          | AIDS                     |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Bulimia                   |                          | Hives or Rash              |                          | Diabetes                 |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| High Blood Pressure       |                          | Chemotherapy*              |                          | Excessive Thirst         |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Low Blood Pressure        |                          | Stomach/Intestinal Disease |                          | Frequent Diarrhea        |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Blood Disease             |                          | Page't's disease           |                          | Cold Sores/Fever Blister |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| High cholesterol          |                          | Recent Weight Loss         |                          | Canker Sores             |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Dizziness/vertigo         |                          | Recent Blood Transfusion   |                          | Stroke                   |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Acid reflux/GERD/ulcer    |                          | Swelling of Limbs          |                          | Herpes                   |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Anemia                    |                          | Leukemia                   |                          | Convulsions              |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Excessive Bleeding        |                          | Hypoglycemia               |                          | Epilepsy or Seizures     |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Hemophilia                |                          | Liver Disease              |                          | Glaucoma                 |                          |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| Congenital Heart Disorder |                          | Hepatitis A (Infectious)   |                          | Tumors or Growths        |                          |                          |                          |

HAVE YOU EVER BEEN ADVISED TO TAKE ANTIBIOTIC PREMEDICATION PRIOR TO DENTAL TREATMENT? YES NO

Have you ever had any other serious illness or surgery not listed above? YES NO

Describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medical Updates

I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient Signature	Reviewed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____