# Robison Family Dental


## Brandon J. Robison, DMD

3590 West 9000 South Suite. 325
West Jordan, Ut 84088
801.748.1399 fax 801.748.1426

## 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 learned about our office.

______________________________________________________________________

## Patient Information

Name___________________________ Birth Date______________ Social Security #_______________
Address_________________________________ City_____________ St_________ Zip_____________
Spouse's Name___________________ Emergency Contact Name:____________________#____________

At times, our office may need to communicate with you quickly. Please provide us with the following information.

Cell Phone #_______________ (May we send you a text for appointment reminders? ☐**Yes** ☐ **No**)
Home Phone _______________ Work Phone______________ Email ___________________________

## 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 You Smoked |
| ☐ | ☐ | Myasthenia Gravis | ☐ | ☐ | Do You or Have You Used a Vape Pen |

***FOR WOMEN ONLY***

☐ ☐ Are You Pregnant? **Due Date**: _______________ ☐ ☐ 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 list any condition not mentioned above:**

______________________________________________________________________________

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

Have you ever taken any osteoporosis medication not named above? ☐ Yes ☐No

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### Written Financial Policy

Thank you for choosing Robison Family Dental. Our primary mission is to deliver the very best and most comprehensive dental care available. An important part of our mission is to make the cost of optimal care as easy and manageable as possible by offering several payment options. You can choose to pay by cash, check, Visa, Mastercard, American Express, or Discover Card. We also offer CareCredit No Interest Patient Payment Plans that allow you to pay over time with convenient, low monthly payments.

Robison Family Dental is a $0 balance office and requires full payment at time of service. Balances reaching beyond 30 days, from time of service, will receive a $39 delinquency charge. Accounts sent to a collection agency will have 33% of the outstanding balance added to the account to offset the cost of collections.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit. We will bill them directly for reimbursement on your behalf. However, insurance companies hold the right to refuse payment despite necessary treatment. In such cases, the responsible party (patient/guardian) is liable for all treatment costs. If the collection of insurance reimbursement reaches beyond 60 days, the responsible party is liable for full balance of the account. In such cases, our office will continue to aid the responsible party by providing any necessary treatment information to the insurance company.

We fully understand that the financial aspect of dental treatment can be overwhelming. Our commitment to you is that, we will strive to estimate the cost of treatment as accurately as possible. Please understand that during treatment, additional costs may occur due to unseen changes in treatment. Please be aware, there is a **$50 fee ( per hour scheduled)** for any appointments cancelled less than 24 hours in advance.

**Patient, Parent or Guardian Signature:** ____________________________________ **Date:** ___________________

Patient Name (Please Print): _______________________________________________

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*You May Refuse to Sign This Acknowledgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

**Please Print Name**

**Signature**

**Date**

**For Office Use Only**

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

____ Individual refused to sign

____Communications barriers prohibited obtaining the acknowledgement

____An emergency situation prevented us from obtaining acknowledgement

____Other (please specify)