Robson Crossing
Family and Cosmetic Dentistry

3446 Winder Highway
Suite 501-Q,
Flowery Branch, GA, 30542

770-297-5110
RobsonCrossingDentistry.com

# Patient Information Form

Name: ______________________________________________________________ Date of Birth: _________________
First Middle Last

Address: __________________________________City:____________________State:_____________Zip:__________

Home Phone: ________________________ Cell Phone: ___________________ Work Phone: ____________________

Email: _________________________________ Soc. Security #:____________________

Check Appropriate Box: Gender: ☐ Female ☐ Male Family Status: ☐ Married ☐ Single ☐ Minor ☐ Other

Person to contact in case of an emergency: _____________________ Phone: ____________ Relationship: ___________

Whom may we thank for referring you to our practice? __________________________________

## Responsible Party

Name of Person Responsible for this Account: ________________________ Relationship to Patient: _________________

Address: _____________________________________________________Best Contact Phone#: ________________

Employer: _____________________________________________________Work Phone#: __________________

Is this person currently a patient in our office? ☐Yes ☐ No

## Insurance Information

Name of Insured: _______________________________________DOB: _____________Soc. Security#: _____________

Name of Employer: ____________________________________________ Work Phone#: ________________________

Insurance Company Name: ________________________________________ Ins phone#:_________________________

Insured's Relationship to Patient: _____________________________________________________

**Let us see your family smile!**

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# Dental History and Information

**Medical History (check all that apply):**

- ☐ Abnormal Bleeding
- ☐ Alcohol
- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Crohn's/Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ HIV/Aids
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis: ○A ○B ○C
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Anemia
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ **Please check this box if you currently take or have ever taken bone replacement medicine.**

**Drug Allergies:**

- € Aspirin
- € Codeine
- € Dental Anesthetics
- € Erythromycin
- € Latex
- € Metals
- € Penicillin
- € Sulfa
- € Tetracycline
- € Other ________________

  ________________________

**Conditions (check all that apply):**

- € Pain/Discomfort
- € Sensitive Teeth
- € Bleeding Gums
- € Bad Taste
- € Clench or Grind Teeth
- € Anxiety Regarding Dental Treatments
- € Excessive Bleeding or Swelling
- € Have had past Treatment for Gum Disease
- € Do you?
  - o Brush Regularly?
  - o Floss Regularly
- € Do you smoke or chew tobacco?
- € Are you happy with your smile?
  - o Yes
  - o No (what would you change?)__________

    ________________________________________
- € Females:
  - o Do you take birth control pills?
  - o Are you currently pregnant?

**List any medications you are currently taking:**

______________________________________________________________________________________________

______________________________________________________________________________________________

**Treatment Authorization:**

I hereby give consent for dental services to be performed that have been agreed upon between the doctor and myself and/or my parent or guardian, including the use and/or prescription of local anesthesia or other medication. I certify that the above is an accurate and thorough statement regarding my medical condition:

Signature: ____________________________________________________________ Date: ________________

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# Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined in advance.

All emergency services or other dental services performed without previous financial arrangements must be paid for in full at the time services are performed, unless other arrangements are made. **We accept all major credit cards and cash; however, this office has a no check policy.**

Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment on all dental services. This office will help prepare the patient's forms or assist in making collections from insurance companies and will credit any collections to the patient's account.

Unpaid balances on patient accounts will be subject to a 5% service charge after a period of 90 days.

I understand that any fee estimate for my dental care can only be extended for a period of six months from the date of the examination.

In consideration for the professional services rendered to me by this practice, I agree to pay for the charges at the time of treatment. I further agree that the charges for services shall be as billed unless subjected to, by me, in writing within the time payment is due. I further agree that a waiver of any breach of any time or condition hereafter shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted.

I grant my permission to employees of this office to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian (responsible party):

_______________________________________________

Relationship to patient: ______________________________ Date: ________________