ACCOUNT REGISTRATION

Date _____

PATIENT INFO

Last Name	Title Mr/Mrs	First Name	M.I.	Sex	Telephone Numbers Home Office

Address	City	State	Zip Code	Cell #

Spouse/Guardian	Email Address	Birth Date

Person Who Referred You	I Accept Responsibility For This Account Signature of Responsible Person, Spouse other Guarantor	Patient SS Number

PERSON FINANCIALLY RESPONSIBLE

Primary Dental Insurance Company
Insurance ID # or SSN _____
Group _____
Employer _____
Date of Birth _____
Authorized Signature For Insurance
_____ / Date _____

Secondary Dental Insurance Company
Insurance ID # _____
Group _____
Employer _____
Date of Birth _____
Authorized Signature To Release
_____ / Date _____

DENTAL HISTORY & 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 _____
1. Do you have or have you had any of the following?

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

_____ Authorized Signature of Covered Person/Employee Date

_____ 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 carier.

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 $1^{1/2}$ finance charge ($18^{\%}$ annuanlly) 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 affect 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 acknowledgment

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

_____ (Signature)

_____ (Date)

For Office Use Only

We attempted to obtain wtitten acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement ccould 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 contracceptives hormong 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 MEDICATONS: Fosamax Bonefos 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	
❑	❑	Heart Trouble/Disease	❑	❑	Acid Reflux/GERD/Ulcer	❑	❑	Chemotherapy*	❑	❑	Cortisone Medication
❑	❑	Heart Murmur*	❑	❑	Anemia	❑	❑	Stomach/Intestinal Disease	❑	❑	Artificial Joint*
❑	❑	Irregular Heart Beat	❑	❑	Excessive Bleeding	❑	❑	Paget's Disease	❑	❑	Venereal Disease
❑	❑	Angina/Chest Pain	❑	❑	Hemophilia	❑	❑	Recent Weight Loss	❑	❑	AIDS
❑	❑	Heart Attack/Failure	❑	❑	Congenital Heart Disorder	❑	❑	Recent Blood Transfusion	❑	❑	Diabetes
❑	❑	Drug Addiction/Alcoholism	❑	❑	Mitral Valve Prolapse*	❑	❑	Swelling of Limbs	❑	❑	Excessive Thirst
❑	❑	Tattoos	❑	❑	Scalet Fever	❑	❑	Leukemia	❑	❑	Frequent Diarrhea
❑	❑	HIV Positive	❑	❑	Lung Disease	❑	❑	Hypoglycemia	❑	❑	Cold Sores/Fever Blister
❑	❑	Yellow Jaundice	❑	❑	Emphysema	❑	❑	Liver Desease	❑	❑	Canker Sores
❑	❑	Artificial Heart Valve*	❑	❑	Frequent Cough	❑	❑	Hepatitis A (Infectious)	❑	❑	Stroke
❑	❑	Rheumatic Fever*	❑	❑	Breathing Problem	❑	❑	Hepatitis B or C	❑	❑	Herpes
❑	❑	Heart Pacemaker*	❑	❑	Cancer	❑	❑	Osteoporosis	❑	❑	Convulsions
❑	❑	Bulimia	❑	❑	Tuberculosis	❑	❑	Kidney Problems	❑	❑	Epilepsy or Seizures
❑	❑	High Blood Pressure	❑	❑	Asthma	❑	❑	Thyroid Disease	❑	❑	Glaucoma
❑	❑	Low Blood Pressure	❑	❑	Bloody Sputum	❑	❑	Parathyroid Disease	❑	❑	Tumors or Growths
❑	❑	Blood Disease	❑	❑	Blood Vessel Surgery	❑	❑	Arthritis/Gout	❑	❑	Psychiatric Care
❑	❑	High Cholesterol	❑	❑	Radiation/X-Ray Treatment*	❑	❑	Rheumatism	❑	❑	Alzheimers Disease
❑	❑	Dizziness/Vertigo	❑	❑	Hives or Rash	❑	❑	Sickle Cell Disease	❑	❑	Shortness of Breath

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