ROBINSON
FAMILY DENTAL

PATIENT INFORMATION

Patient Name: _____ Date: _____
Social Security Number: _____ Date of Birth: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Employer:_____ Phone Number:_____

Do you have dental insurance? ▢ **YES** ▢ **NO**
Name of insurance company: _____
Policyholders name: _____ DOB:_____ Policy #: _____

Chief Complaint: _____
Date of Last dental visit: _____ Reason for last visit: _____
Were x-rays taken? ▢ **YES** ▢ **NO**
Are you happy with your smile? ▢ **YES** ▢ **NO**

Please check all that apply:

- ▢ HIV/AIDS
- ▢ Anemia
- ▢ Arthritis
- ▢ Artificial Heart Valve
- ▢ Artificial Joint(s)
- ▢ Asthma
- ▢ Blood Diseases
- ▢ Cancer/Chemotherapy
- ▢ Diabetes
- ▢ Dizziness
- ▢ Dry Mouth
- ▢ Epilepsy
- ▢ Excessive Bleeding
- ▢ Glaucoma
- ▢ Heart Disease
- ▢ Hepatitis
- ▢ High Blood Pressure
- ▢ Kidney Disease
- ▢ Liver Disease
- ▢ Mental Disorders
- ▢ Osteoporosis
- ▢ Pacemaker
- ▢ Radiation Treatment
- ▢ Respiratory Problems
- ▢ Rheumatic Fever
- ▢ Snore/Sleep Apnea
- ▢ Stomach Problems
- ▢ Stroke
- ▢ Thyroid Disease
- ▢ Tuberculosis
- ▢ Unexplained Weight Loss

Please list all medications that you are taking:

Are you currently taking a blood thinner? ▢ **YES** ▢ **NO**
Are you currently taking a bisphosphonate? ▢ **YES** ▢ **NO**
Have you ever taken an antibiotic for dental treatment? ▢ **YES** ▢ **NO**

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If yes, please explain: _____
Are you under the care of a physician? ▢ **YES** ▢**NO** If yes, please explain: _____
_____
Name of Physician: _____ Phone number: _____
Have you ever had any complications following a dental treatment? ▢ **YES** ▢ **NO**
If yes, please explain: _____
Do you have any health problems that need further clarification? ▢ **YES** ▢ **NO**
If yes, please explain _____

Please list ALL allergies:_____
_____

Pharmacy Name: _____ Pharmacy Phone Number: _____
Pharmacy Address: _____

I clarify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient, parent or guardian: _____

Who may we thank for referring you to our practice?
▢ Another patient
▢ Dental office
▢ Work
▢ School
Name of person(s) or office referring you to our practice:_____