Finanne-Robison Dental

520-B Burkarth Rd. Warrensburg, MO 64093 Ph. 660-747-7161

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as *completely* as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name (Last, First, Middle)_____ Nickname_____
Address_____ Phone# (hm)_____ (wk)_____
City_____ State_____ Zip_____ S.S.#_____/_____/_____
D.O.B_____ Single_____ Married_____ Male/Female
Email address_____ Cell Phone #_____

MEDICAL AND DENTAL HISTORY

Physician's Name & Phone #_____
Date of last physical exam or Dr. visit_____
Under a physician's care now or recently? YES___ NO___ Describe if yes: _____
Have you ever had any serious illnesses, operations or blood transfusions? YES___ NO___
Explain if yes:_____
Women Only: Are you pregnant? YES___ NO___ If yes: How many months? _____ Breast-feeding? YES___ NO___
Are you presently taking any medication routinely? (Birth control pills, shots, implant, hormone therapy, etc.) YES___ NO__
If yes, describe:_____

Please circle if you have had or suspected that you had any of the following:

AIDS/HIV positive	Glaucoma	M. Sclerosis
Anaphylaxis	Headaches	Pacemaker/heart surgery
Anemia	Heart Murmur	Psychiatric care
Arthritis	Heart problems	Radiation treatments
Artificial heart valves	Hemophilia/Abnormal Bleeding	Respiratory disease
Artificial joints/joint replacement	Herpes	Rheumatic/Scarlet Fever
Asthma	Hepatitis/Jaundice	Shortness of breath/chest pain
Blood Disease	High/low blood pressure	Stroke
Cancer	Jaw pain	Surgical Implant
Chemical dependency	Kidney disease/malfunction	Swelling of feet/ankles
Chemotherapy	Liver disease	Thyroid disease/malfunction
Circulatory problems	Lung disease	Tonsillitis
Diabetes	Lupus	Tuberculosis
Emphysema	Mitral Valve Prolapse	Ulcer/colitis
Epilepsy		Venereal disease
Fainting		

Circle if you are allergic to or suffer ill effects from any of the following:

Aspirin	Codeine	Dental Anesthesia	Household bleach
Latex	Metal/Nickel	Penicillin	Other:_____

Circle any of the following medications that you are/have taken:

Anticoagulants	Blood thinners	Fenfluramine/Dexfenfluramine (Fen-Phen)
Sedatives	Steroids/Cortisone drugs	Fosamax or Bisphosphonate drugs

(Please Complete Both Sides)

List all current medications (RX and/or OTC):

Drug Name	Dosage	Indication
a.		
b.		
c.		
d.		
e.		

Circle if you have had a problem with any of the following:

Bad Breath	Grinding/clenching of teeth	Sensitivity to hot
Bleeding Gums	Loose teeth/broken fillings	Sensitivity to sweets
Clicking/popping jaw	Periodontal treatment	Sensitivity to biting
Food collection between teeth	Sensitivity to cold	Sores/growths in mouth

Date of last dental care:_____ Former Dentist: _____
How do you feel about the appearance of you teeth: _____
_____
Have you had any teeth removed? Yes/No Date _____ Have any missing teeth been replaced? Yes/No Date _____
Ever experience an adverse reaction during or in conjunction with a medical or dental procedure? Yes/No
If yes, explain: _____

Please circle your choice of pain relief/patient comfort during dental procedures:

Local anesthetic Nitrous Oxide (laughing gas) Both None

PERSON RESPONSIBLE FOR ACCOUNT

Name (Last, First, Middle) _____Phone# (Hm) _____(Wk)_____
Single __ Married ___ Divorced ___ Widowed ___ S.S# _____/_____/_____ D.O.B. _____
Home Address _____ City_____ State _____ Zip _____
Mailing Address (if different) _____
City _____ State _____ Zip _____ Employer: _____
Spouse _____ Spouse Employer: _____
Closest Relative not living with you: _____ Phone # _____
Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Subscriber Name _____Relationship to Patient _____
Address: _____S.S.# : _____/____/_____ D.O.B. _____
Employer/Plan Name _____ Address _____
Insurance Company _____ Phone # _____
Address _____ Subscriber # _____
Plan/Group # _____

ADDITIONAL COVERAGE

Is Patient covered by additional insurance? Yes _____ No _____
Subscriber Name _____ Relationship to Patient _____
Address: _____S.S.# : _____/____/_____ D.O.B. _____
Employer/Plan Name _____ Address _____
Insurance Company _____ Phone # _____
Address _____ Subscriber # _____
Plan/Group # _____

AUTHORIZATION

I have reviewed all information and believe it is accurate to the best of my knowledge. I authorize the release of all Information necessary to obtain benefits from my insurance, payable to the dentist for all services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. Any balance not expected by insurance is due at the time of service and will be paid by:

Cash Check MC/Visa/Discover

SIGNATURE **DATE**