Lake Oswego Dentistry
Jon Robinson D.M.D.
310 N. State Street Suite 310
Lake Oswego, OR 97034

Welcome to Lake Oswego Dentistry

Our Promise to You

We promise to do everything possible to see you on time and as appointed. **We promise** to provide you with the highest quality of Dental care possible in an exceptional, comfortable and caring environment. **We promise** to do everything within our power to make each and every visit as comfortable and relaxing for you as we possibly can. **We promise** to keep the fees for our services as low as possible while still allowing us to provide you with the outstanding dental experience that you deserve. **We promise** not to compromise your care if your insurance company only pays for inferior treatment options. **We promise** to educate you as to your options and the benefits of treatment, or the risks of non-treatment, and let you choose what is best for your personal circumstances.

When we schedule an appointment for you we set aside time exclusively for you. The treatment room is sterilized, appropriate instruments are prepared and your chart is thoroughly reviewed prior to your appointment. In addition, any precision lab work required is crafted and readied for your arrival. In other words, we are thoroughly prepared for you. We spend much time and effort preparing for your visit.

We are asking you to help us keep the cost of this extraordinary care down by respecting our time and effort on your behalf. **Please help us by arriving on time for your appointments. When absolutely necessary to reschedule an appointment: Please give us at least two working days notice.**

Unfortunately, when patients cancel on short notice or fail to show for a scheduled appointment, all of this preparation and time is wasted. In addition, many other patients who would have liked to have that appointment had to be scheduled into the future, forcing them to cope without treatment for longer than necessary.

We appreciate you helping us keep this promise to you and all our patients.

Thank you for your help and cooperation and Welcome to Lake Oswego Dentistry!

Sincerely,

Dr. Jon Robinson DMD and Team

Patient's Name: **How do you wish to be addressed:** **Today's Date:**

_______________________________ ______________________ _________

Last First M

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Student

Residence: Street Address____

City______________________ State________________ Zip Code_________________

Telephone: Home____________________ Work_________________ Extension_______

May we confirm your appointments at work? ______ E-mail address____________________

Patient's Employer:____________________Address_____________________________

Patient's Social Security # (for Insurance): **Date of Birth:**

Whom may we thank for referring you to our office?

Spouse Name: ____

Spouse Employer: ____

Spouse Social Security #(for Insurance): __________________________________

Spouse Date of Birth:

Do you have other family members in this practice? ___________________________

Who may we notify in case of emergency? Name: Telephone:

Dental Insurance Information:

Name of Insurance Company: ____

Address of Company:____

Phone Number:____

Group # or Policy #________________________ Effective Date:_______________________

Name of Insured Person: Social Security Number:

PATIENT REGISTRATION

Patient's Name:

Name of Primary Physician: ______________________________

Phone Number: ____________________ Date of last physical: ________

Have you been hospitalized or had any **serious illness** during the past five years? **Y** or **N**
If so, please explain ______________________________________

Have there been any **changes** in your health during the last year? **Y** or **N**
If so, please explain______________________________

Have you **ever had** any of the following?

___Anemia	___Rheumatic Fever	___Kidney Problems
___AIDS	___Tuberculosis	___High/Low Blood Pressure
___HIV+	___Asthma	___Artificial Joint Replacement
___Venereal Disease	___Heart Murmur	___Fainting Spells
___Diabetes	___Abnormal Heart Condition	___Stomach Ulcers
___Glaucoma	___Abnormal Bleeding	___Hepatitis
___Epilepsy	___Cancer	___ Allergies___________

Do you have **allergies** to any of the following: If so, please explain:

___Penicillin	___Codeine	___Other medications___________
___Local Anesthetics	___Narcotics	___ Latex
___Aspirin	___Sulfa	

Does your mouth become dry frequently? **Y** or **N**
Does anyone in your family have diabetes? **Y** or **N**
Do you wear contact lenses? **Y** or **N**
Do you or have you ever smoked or chewed tobacco? **Y** or **N**

Please list **all medications**, including birth control pills and over the counter medications that you are currently taking:

Medication	Reason
________________	________________
________________	________________
________________	________________
________________	________________

Do you take any herbal or naturopathic medications? If so, please list:

Women: Are you now or do you expect to be pregnant during the next year? **Y** or **N**
______ months along

Patient Signature: Date:

I have reviewed and updated my medical history with Dr. Robinson and his team.

MEDICAL HISTORY

What is the primary purpose of this visit?

When did you last have a complete dental examination?

Have you avoided regular dental care? If so, please explain: Y or N

Do you currently suffer from any of the following:

___Bleeding gums
___Cold sensitivity
___Hot sensitivity
___Bad breath
___Pain while chewing
___Unpleasant tastes
___Sensitivity to sweets

How often do you brush? ______ **times per day**
How often do you floss? ______ **times per week**

Do you drink soda on a regular basis? Y or N
Do you have clicking or popping sounds in your jaw joint? Y or N
Does your jaw ever lock open or closed? Y or N
Do you have frequent headaches? Y or N
Have you ever been treated for headaches or other head and neck problems? Y or N
Do you clench or grind your teeth at night or during the day? Y or N
Do you have missing teeth that have not been replaced? If so, explain: Y or N

Have you had any of the following:
___ Oral Surgery
___ Orthodontics (braces)
___ Periodontal Surgery

Do you have any problems becoming numb for dental procedures? Y or N
Do you have any fears or anxieties about dental work? Y or N
If so, please explain:

Do you know the causes and treatments of gum disease? Y or N
Are you happy with the appearance of your smile? Y or N
If not, please explain:

How important are your teeth to you? (please circle one)

1 = not important at all 1 2 3 4 5 5 = extremely important

Patient Signature: ______________________________ **Date:**______________

DENTAL HISTORY

Dr. Jon C. Robinson, D.M.D., P.C.
310 N. State Street
Suite 310
Lake Oswego, OR 97034

Payment Guideline Acknowledgment

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy. For the convenience of our patients we offer the following methods of payment of fees:

A. Payment in full by cash, bankcard or alternate financing for each appointment as service is rendered.

B. For insurance patients we will accept payment directly from the insurance company. You will be responsible for the percentage your insurance company does not cover and we do require that this and any deductible or non-covered fees be paid at each visit. In the event of duplicate payment you will be reimbursed promptly.

C. Bank Charge cards-Visa and MasterCard are accepted.

D. Alternate financing (Care Credit) accounts are gladly accepted. We will be glad to assist you in filling out an application. Credit approval is required.

E. Major services-Appliances, crowns, bridges, veneers, partials and dentures. Payment of ½ at the initial appointment and balance at the completion unless prior arrangements have been made with our financial coordinator.

F. Basic Services- Fillings, periodontal treatment, extractions, and root canals. Payment due at each appointment unless prior arrangements have been made with our financial coordinator.

G. Preventive-Exams, X-Rays, cleanings, etc. Payment due at each appointment.

H. All home care products are required to be paid in full at each appointment.

I. If any other payment plan is required we will consider it after obtaining credit report from a professional agency.

Please be aware that any parent bringing a child to our office is legally responsible for payment of all services rendered.

Our office staff understands dental insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract.

It is important that you realize, however that...

1. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
2. Our fees generally, but not necessarily, fall within the usual and customary fee structure, determined by your carrier.
3. Not all dental services are a covered benefit in all contracts.
4. You (not the insurance company) are responsible to us for all of our fees for services rendered to you.
5. For patients who have insurance, an ESTIMATE will be given of the benefits that the insurance company is expected to pay.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We appreciate the opportunity to serve you.

______________________________ ____________________
Patient or Responsible Party Date

Personal Health Information Disclosure Agreement for Lake Oswego Dentistry

I, ________________________________, do hereby grant permission for Lake Oswego Dentistry, to disclose my personal health information to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)

____

____

____

Information to be disclosed (please check):

- ☐ Appointment dates and times
- ☐ Treatment plans and referrals
- ☐ Financial and billing information
- ☐ Any other pertinent dental health information related to treatment at this office.
- ☐ None of the above

I understand that this permission will remain in effect unless a written cancellation has been provided to Lake Oswego Dentistry.

____ ______________________

Patient Signature Date

____

Patient's Date of Birth

____ ______________________

Witness Signature Date