NORTHEAST FLORIDA
Periodontics & Dental Implants
• EXCELLENCE ALWAYS •

ROGER D. ROBINSON JR., D.M.D., M.S.
DIPLOMATE, AMERICAN BOARD OF PERIODONTOLOGY

CONFIDENTIAL
PATIENT QUESTIONNAIRE

DATE			
NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.			
CELL PHONE NO.			
E-MAIL ADDRESS			
BIRTH DATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY	
ADDRESS	
GROUP NO.	
NAME OF INSURED PARTY	
DATE OF BIRTH	DATE EMPLOYED
EMPLOYEE SOCIAL SECURITY NO.	
INSURED PARTY ID NO.	
INSURANCE PHONE NO.	

SECONDARY CARRIER

INSURANCE COMPANY	
ADDRESS	
GROUP NO.	
NAME OF INSURED PARTY	
DATE OF BIRTH	DATE EMPLOYED
EMPLOYEE SOCIAL SECURITY NO.	
INSURED PARTY ID NO.	
INSURANCE PHONE NO.	

EMPLOYMENT INFORMATION

YOU

OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	
CITY, STATE, & ZIP	PHONE

YOUR SPOUSE

NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	
CITY, STATE, & ZIP	PHONE

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? NAME: RELATIONSHIP:		
REFERRED TO US BY		
PERSON TO CONTACT FOR EMERGENCY		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP

OUR OFFICE POLICY

To enable us to establish the best relationship with our patients and to avoid misunderstanding in the future, we have established certain office policies.

Each patient we treat is entitled to and will receive a thorough and careful examination. We are dedicated to the principle of doing our best in treating all patients with the highest quality treatment possible.

It is customary to pay for dental services when treatment is rendered unless prior written arrangements have been made. We accept Visa, MasterCard, American Express, & Discover. We also participate with CareCredit and The Lending Club, which provide interest free financing (*interest accrues if terms not met*, please ask us for details). For our patients who have dental insurance, we will file your claim and request the payment be sent directly to us. You will be responsible for any portion not covered by your insurance at the time treatment is rendered. *Some insurance policies will not assign benefits to out of network providers; in these cases, unfortunately we are unable to accept assignment of benefits. We will however file the claim for the insurance company to reimburse you directly.* If a claim for which we have accepted assignment of benefits remains outstanding for more than 60 days or if we must appeal a negative decision on your behalf, *you must pay the existing balance and we will reimburse you directly when the insurance company pays the claim.*

Returned checks will be subject to a returned check fee.

Should your account need to be turned over for outside collection, a 35% collection fees will be incurred.

It is our office policy that 24 hours notice must be given if you are forced to cancel an appointment (Surgery appointments need 48 hours notice). A broken appointment fee may be charged and payment will be the patient's responsibility. After two broken appointments, we will place your file in an "inactive status" and special arrangements must be made to reactivate it.

Signature _____
(Patient or Guardian)

CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed necessary by the doctor to make a thorough diagnosis of _____'s dental needs.
(name of patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____

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DENTAL HISTORY

Patient Name

__Welcome!__ So that we may provide you with the best possible care, please complete this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

Previous dentist's name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.)_____

Do you have any dental problems now? **Yes** ☐ **No** ☐

If yes, please describe: _____

	Yes	No
Are any of your teeth sensitive to:		
Hot or cold?	☐	☐
Sweets?	☐	☐
Biting or Chewing?	☐	☐
Have you noticed any mouth odors or bad tastes?	☐	☐
Do you frequently get cold sores, blisters or any other oral lesions?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have your parents or spouse experienced gum disease or tooth loss?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Does food tend to become caught in between your teeth?	☐	☐
If yes, where? _____		
Do you:		
Clench or grind your teeth while awake or asleep?	☐	☐
Bite your lips or cheeks regularly?	☐	☐
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Have tired jaws, especially in the morning?	☐	☐
E-Cigarette / Smoke / chew tobacco?	☐	☐

	Yes	No
Have you ever had:		
Orthodontic treatment?	☐	☐
Oral surgery?	☐	☐
Periodontal treatment?	☐	☐
Your teeth ground or the bite adjusted?	☐	☐
A bite plate or mouth guard?	☐	☐
A serious injury to the mouth or head?	☐	☐
Is so, please describe, including cause: _____		
Have you experienced:		
Clicking or popping of the jaw?	☐	☐
Pain? (joint, ear, side of face)		
Difficulty in opening or closing the mouth?	☐	☐
Difficulty in chewing on either side of the mouth?	☐	☐
Headaches, neckaches or shoulder aches?	☐	☐
Sore muscles (neck, shoulders)?	☐	☐
Are you satisfied with your teeth's appearance?	☐	☐
Would you like keep all of your teeth all of your life?	☐	☐
Do you feel nervous about having dental treatment?	☐	☐
If so, what is your biggest concern? _____	☐	☐
Have you ever had an upsetting dental experience? If yes, please describe: _____	☐	☐

Is there anything else about having dental treatment that you would like us to know? Yes ☐ No ☐

If yes, please describe_____

_____

_____

Patient Name

MEDICAL HISTORY

Yes No

1. Have you been under the care of a medical doctor during the past two years? ☐ ☐
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ☐ ☐
3. Are you taking any medication, drugs or pills now? ☐ ☐
   If yes, please list name and dosage: _____
4. Are you aware of having an allergic (**or adverse**) reaction to any medication or substance? ☐ ☐
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ☐ ☐
6. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐
   Name of physician or dentist making recommendation _____
   _____
7. Indicate which of the following you have had, or have at present.

	Yes	No		Yes	No		Yes	No
Heart (Disease, Surgery, Pacemaker)	☐	☐	Kidney Trouble	☐	☐	Hepatitis A (infectious) B (serum)	☐	☐
Chest Pain	☐	☐	Ulcers / GERD	☐	☐	Venereal Disease	☐	☐
Artificial Heart Valve	☐	☐	Thyroid Problems	☐	☐	HIV / AIDS	☐	☐
Congenital Heart Disease	☐	☐	Glaucoma	☐	☐	Cold Sores / Fever Blisters	☐	☐
Heart Murmur	☐	☐	Contact Lenses	☐	☐	Blood Transfusion	☐	☐
High / Low Blood Pressure	☐	☐	Emphysema / COPD	☐	☐	Hemophilia	☐	☐
Rheumatic Fever	☐	☐	Chronic Cough	☐	☐	Sickle Cell Disease	☐	☐
Autoimmune Dysfunction	☐	☐	Tuberculosis	☐	☐	Bruise Easily	☐	☐
Arthritis / Rheumatism	☐	☐	Asthma	☐	☐	Liver Disease	☐	☐
Cortisone Medicine	☐	☐	Hay Fever	☐	☐	Yellow Jaundice	☐	☐
Swollen Ankles	☐	☐	Latex Sensitivity	☐	☐	Neurological Disorders	☐	☐
Stroke	☐	☐	Allergies or Hives	☐	☐	Epilepsy or Seizures	☐	☐
Diet (Special / Restricted)	☐	☐	Sinus Trouble	☐	☐	Fainting or Dizzy Spells	☐	☐
Artificial Joints (hip, knee, etc.)	☐	☐	Radiation Therapy / Chemotherapy	☐	☐	Nervous / Anxious	☐	☐
Diabetes / AC1	☐	☐	Cancer	☐	☐	Psychiatric / Psychological Care	☐	☐

Yes No

8. Do you use more than two pillows to sleep? ☐ ☐
9. Have you lost or gained more than 10 pounds in the past year? ☐ ☐
10. Do you have or have you had any disease, condition, or problem not listed? ☐ ☐
    If yes, please list: _____
11. **Women**, Is there any possibility you may be **pregnant**? ☐ Yes ___ Months ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ ☐
12. Have you ever taken any medication for osteoporosis / bone building purposes (ex: Fosamax, Boniva)? ☐ ☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____ Date _____

History Review

Doctor's Signature _____ Date _____

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Northeast Florida Periodontics & Dental Implants

Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Northeast Florida Periodontics & Dental Implants. I hereby authorize, as indicated by my signature below, Northeast Florida Periodontics & Dental Implants to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name:_____

Address:_____

Signature:_____ Date:_____

Please check your preferred means of communication:

□ You may contact me at my home telephone number: _____
□ You may contact me on my mobile telephone number: _____
□ You may contact me on my work telephone number: _____
□ You may send me an email at: _____
□ Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____ Relationship: _____ Date ___/___/___
added☐/removed☐

2. _____ Relationship: _____ Date ___/___/___
added☐/removed☐

3. _____ Relationship: _____ Date ___/___/___
added☐/removed☐

****For Office Use Only****We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could 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): _____
Staff Person Initials: _____

3595 CARDINAL POINT DRIVE
JACKSONVILLE, FL 32257

P: 904-737-2040
F: 904-737-2051

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FINANCIAL POLICY

Payment is expected at time of treatment unless prior written arrangements have been made.

Northeast Florida Periodontics & Dental Implants accepts several forms of payment for dental treatment provided at our office:

Cash, personal check (a fee will be charged for returned checks)***, credit cards:*** MasterCard, Visa, Discover, American Express

LendingClub Patient Solutions & Care Credit: We have two outside financing companies that provide our patients with plans that have 6 – 12 months interest free (*If paid within the promotional period. Otherwise, interest accrues from purchase date. Minimum monthly payment required*), based on the amount of the plan. A short application is required and you may apply online at your convenience ***(a link to Care Credit can be found on our website)*** or you may fill out an application in the office at least one week prior to your appointment and we will submit it for you. A decision is usually given immediately upon completion of the application.

Dental Insurance: Understanding your insurance coverage can be quite a challenge. ***Our goal is to assist you in maximizing your benefits.*** We care for patients from many different employers. Each company pays an insurance premium for specific coverage, which fits the employer's budget, and each plan is different in its covered services. We encourage you to become familiar with your policy exclusion, deductibles and required co-payments.

Our service to you includes:

1) *Filing your insurance and requesting payment be sent directly to us. *Some insurance companies will not assign benefits to providers that are out-of-network; in these cases, unfortunately we are unable to accept assignment of benefits. We will however file the claim for the insurance company to reimburse you.*
2) Following American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1) Payment of fees not covered by your insurance plan at time of treatment. A pretreatment estimate will need to be obtained to determine benefits. *If you would prefer not to wait on the pretreatment estimate to receive treatment you may pay for the treatment upfront at the time of treatment and allow the insurance company to reimburse you.*
2) Please understand that the insurance policy belongs to **you** and we have no leverage to obtain payment from your insurance carrier.
3) Realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called UCR) and exclude some procedures based on policy limitations, prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, **not** our fees or recommended treatment.
4) **If an insurance claim remains outstanding for more than 60 days or if we must appeal a negative decision on your behalf, you must pay the existing balance and we will reimburse you when the insurance company pays the claim.*

I understand I am responsible for all charges associated with this account and interest charges of 1.5% per month will accrue on unpaid balance.

****These terms are subject to change without prior notice at the discretion of Northeast Florida Periodontics & Dental Implants.****

_____

Responsible Party Name (Please Print)

_____

Responsible Party Signature

_____

Date

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

This release is strictly designated to give permission to Dr. Roger D. Robinson Jr., DMD, MS, to use my digital patient photo series. I will allow these photos to be shared with other professionals and patients strictly in an educational setting in office and on various digital platforms (i.e. Company Facebook and website). Dr. Robinson will have permission to use these photos in the manner described above unless I request him to no longer use them. A written request form is available to do so. I understand that by allowing Dr. Robinson to use my photos, he is able to share "before and after" images to educate and explain procedures and possible results of treatment. I understand that I will not be compensated for the sharing of these photos. I understand that I have the option to decline this request, and am not obligated in any way to provide permission to use these photos.

I will allow Dr. Roger D. Robinson Jr., DMD, MS, to share my digital patient photos with other patients and/or professionals in an educational setting.

☐ _____Full Photo Series (including full face shots) ☐ _____Close Up Photos Only (no full face)

____

Patient Name

____

Signature (Parent/Guardian if under 18 years old)

____

Date

- -

I am denying/retracting permission for my photos to be shared with other patients/professionals.

____

Patient Name

____

Signature (Parent/Guardian if under 18 years old)

____

Date

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Code of Conduct

In keeping with our motto of "Excellence Always" and for the health and safety of our patients and staff we ask that you adhere to the guidelines set forth in our Code of Conduct.

- Physical assault, inflicting bodily harm or any other act of violence will not be tolerated.
- Causing damage to property or equipment is not permitted.
- Harassment, intimidation or threats of violent acts by phone, letters, emails, or any other form of communication written, electronic or in person will not be tolerated. Law enforcement will be notified.
- Please respect all patients' right to privacy as protected by Federal Law.
- Photographs or video taping of a person is not permitted without that person's consent.
- The use of alcohol and/or illegal drugs is not allowed on the property.
- For the safety of your children and others please supervise children at all times.
- Northeast Florida Periodontics & Dental Implants is a tobacco and smoke free environment – including E-Cigarettes.

If you observe any violations of these policies please report it to any staff member. Staff, patients or visitors violating these policies will be removed from the property and/or dismissed from the practice.

Patient Signature _____ Date _____