Robinson & Hamblen
GENERAL
DENTISTRY
dentistry with a smile...

Kelly S. Robinson D.D.S. John David Hamblen D.D.S. Jarred Dewbre D.D.S.

Welcome to our office! We look forward to meeting you at your first appointment. Your new patient appointment is scheduled with Dr. Robinson and Melody, our treatment coordinator. During that visit, the following treatment can be expected:

- *A comprehensive oral evaluation*
- *Panoramic radiograph*
- *Full Mouth Series Radiographs*
- *Diagnostic casts*
- *Intra oral photographs*
- *Extra oral digital photographs*
- *Digital smile analysis*
- *Oral cancer screening*
- *Occlusion analysis*
- *Temporomandibular joint analysis*
- *Periodontal evaluation*
- *Baseline bacterial saliva test*

The total investment for this visit is $389. If you have dental insurance, most customary dental plans pay around ~$200. Your portion will be $189.

After this visit, you will return to our office for your complimentary consultation and case presentation with the doctor. Once again, welcome to our office and we look forward to meeting you!

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PLEASE COMPLETE AND RETURN TO BUSINESS OFFICE:

PERSONAL INFORMATION

Name Last	First	Middle			Today's Date:
Address Street or PO Box #	City	State	Zip	Phone Number: Home: Work:	
Cell phone:	Email address:			Social Security Number:	
Age:	Birth Date Mo. Day Year	Occupation		Married ( ) Unmarried ( ) Separated ( )	

IF PATIENT IS A CHILD, USE PARENT OR GUARDIAN INFORMATION FOR THE NEXT FIVE LINES

Mother's Name	Address			Phone Number: Home: Work:
Date of Birth	Social Security #: Drivers License #:	Occupation		Employer
Father's Name	Address			Phone Number: Home: Work:
Date of Birth	Social Security #	Occupation		Employer

INSURANCE INFORMATION

Insured Person's Full Name	Date of Birth	Relationship to Patient
Social Security Number	Insurance ID # (if different than SS#)	Work Phone
Insurance Company Name	Group or Union Name	Group or Local Number
Employer's Name	Full Address of Employer	

GETTING TO KNOW YOU

1. Why did you select our practice?
2. Whom may we thank for referring you?
3. Is another member of your family or relative a patient in our practice?
4. Person to contact for emergency:_____ Phone:_____
5. When was your last dental visit?_____
6. When was the last time you had complete dental radiographs taken?_____
   Name and Address of last Dentist:
7. Have you ever had any teeth removed?_____
   How long have these teeth been missing?_____
   Have these teeth been replaced?_____
   How: ___Bridge ___Partial ___Denture ___Implants

PAYMENT ALTERNATIVES

Please check appropriate choice(s):

_____1. As a special service to you, we offer a cash courtesy if you pay for your entire treatment plan in full, in advance.
_____2. Cash and personal checks are accepted as your treatments are provided.
_____3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.
_____4. Mastercard, Visa, Discover and American Express.
_____5. For long term or extended payments, we offer two healthcare financing programs, which when you are accepted, will allow extended small monthly payments for the treatment received.

FOR ALL PATIENTS:

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible Party Relationship Date

PLEASE COMPLETE MEDICAL HISTORY ON THE BACK.

1. How do you feel about getting and maintaining a healthy mouth?_____

2. How do you feel about the appearance of your teeth?_____

3. If you could change anything about your smile, what would you change? _____

4. Are you having dental problems at this time? _____Yes _____No
5. Do your gums bleed at any time? _____Yes _____No
6. Are you very nervous about having dental treatment or ever had a bad experience in the dental office? Yes___ No___
8. Have you been under the care of a medical doctor during the past two years? _____Yes _____No
   If yes, for what reason?_____
   Please provide the name and telephone number of your physician._____
9. Have you been a patient in the hospital during the past two years? _____Yes _____No
   If yes, for what reason?_____
10. Are you now taking any medicines or have you taken any during the past two years? _____Yes _____No
    Please list current meds: (or attach list)_____

    Past meds:_____
11. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any drugs or medicines? If yes, please list:_____ _____Yes _____No
12. Have you ever had excessive bleeding requiring special treatment? _____Yes _____No
13. Do you use any tobacco products? _____Yes _____No
14. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? _____Yes _____No
15. Do your ankles swell during the day? _____Yes _____No
16. Have you lost or gained more than 10 pounds in the last year? _____Yes _____No
17. Do you have any pins, screws or joint replacements? _____Yes _____No
18. Do you ever wake up from sleep short of breath? _____Yes _____No
19. Are you on a special diet? _____Yes _____No
20. Do any of the following apply in either past or present:

Y	N		Y	N		Y	N	
		Heart Valve Prolapse			High Blood Pressure			Cortisone Medication
		Heart Failure			Anemia			Arthritis
		Heart Disease or Attack			Asthma			Pain in Jaw Joints
		Cardiovascular Disease			Emphysema			X-Ray or Cobalt Treatment
		Angina Pectoris (chest pain)			Shortness of Breath			**Cancer or Tumors**
		Rheumatic Fever			Hay Fever			**Chemotherapy**
		Congenital Heart Lesions			Allergies or Hives			Thyroid Disease
		Scarlet Fever			Fainting or Dizzy Spells			Glaucoma
		Artificial Heart Valve			Epilepsy or Seizures			HIV Positive (AIDS)
		Heart Pacemaker			Nervousness			Venereal Disease
		Heart Surgery			Psychiatric Treatment			Cold Sores or Fever Blisters
		Artificial Joint of any Type			Any Form of Eating Disorder			Genital Herpes
		Diet Medication			Recreational Drug Use			Kidney Trouble
		Heart Murmur			Drug Addiction/Alcoholism			Diabetes
		Bruise Easily			Tuberculosis (TB)			Ulcers
		Blood Transfusion			Any Form of Hepatitis			Stroke
		Hemophilia			Liver Disease			Birth Control Medication
		Sickle Cell Anemia			Rheumatism			Pregnancy - Due Date

_____

NOTES:
Initial BP:_____

Date:_____
Medical History Reviewed By: _____

We welcome you to our practice and look forward to helping you discover "Dentistry with a Smile!"

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Consent to Perform Dentistry:

1. I hereby authorize and direct Kelly Robinson, D.D.S., John David Hamblen, D.D.S. and/or dental auxiliaries of their choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
    A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
    B. Application of plastic "sealants" to the grooves of the teeth.
    C. Treatment of diseased of injured teeth with dental restorations (fillings and crowns).
    D. Replacement of missing teeth with dental prostheses. (bridges, partial dentures, full dentures)
    E. Removal (extraction) of one or more teeth.
    F. Treatment of diseased or injured oral tissues (hard and/or soft).
    G. Use of sedative drugs to control apprehension and/or disruptive behavior.
    H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
    I. Use of general anesthesia to accomplish the necessary treatment.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risk/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indention or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctors to use photographs, radiographs, and other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

DATE:_____

Patient Name:_____
Name of Parent or Guardian:_____
Relationship to Patient:_____

Signature of Patient, Parent or Guardian:_____

Witness:_____

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Assignment of Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be paid by your insurance company. The following provisions identify our procedure governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance benefit. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

- We require you to pay the estimated co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. Our computer system is set to track payment schedules for hundreds of plans, allowing our team to estimate your co-payment. Please note that this is an ESTIMATE only. If there is an additional balance after insurance has paid we will bill you.

- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company.

- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and understand the above conditions. I hereby authorize my insurance company to pay my dental benefits directly to the doctor.

Signature of Patient/ Responsible Party Date

Robinson & Hamblen
GENERAL
DENTISTRY

Kelly S. Robinson, D.D.S. John David Hamblen D.D.S.

PLEASE COMPLETE AND RETURN TO BUSINESS OFFICE:

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

The following people have permission to obtain information:

_____

_____

_____

For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_____ Patient refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Describe below)

_____

_____

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review this carefully. If you have any questions about this Notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Use and Disclosures of Protected Health Information

You will be asked to sign an Acknowledgement of Receipt of Notice of Privacy Practices. Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at times to a dental laboratory or specialist.

Payment: Your protected health information will be used to obtain payment for services we provide to y. This may include certain activities that you insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of you protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, you name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Others uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure or all or part of your protected health information. If you are not present or able to agree or abject to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends: Unless you object, we may disclose to a member of your family; a relative, a close friend or any other person you identify, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment to make reasonable decisions in your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays or other similar forms of health information.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent

Required by Law: We may use or disclose your protected health information when we are required to do so by law.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your Acknowledgement of Receipt of Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence of the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

Military Activity and National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody, the protected health information of inmates or patients under certain circumstances.

Required Uses and Disclosures: Under the laws, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

Your Rights

You have the right to inspect and copy your protected health information. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make the request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

You have the right to request a restriction of your protected health information. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

You have the right to request alternative communications from us. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

You have the right to request an amendment to your health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

You have the right to make a complaint about our privacy policies. If you are concerned that we have violated your privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the bottom of this page. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office of the Department of Health and Human Services.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date: December 17, 2013

Privacy Officer: Tonya Ellerd Telephone: (806)794-1131
Fax: (806)794-1103 Email: crobinson@crobinsondds.com
Address: 4215 85th Street, Lubbock, TX 79423