PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Gender: ☐ Male ☐ Female ☐ Unknown Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Cell Phone _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

John J Roberson,D.D.S.

Patient Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Are you on a special diet?	○ Yes ○ No		
Do you use tobacco?	○ Yes ○ No		
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes	

Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement?	○ Yes ○ No	If yes	
Artificial (prosthetic) heart valve?	○ Yes ○ No	If yes	
Previous infective endocarditis?	○ Yes ○ No	If yes	
Has a physician recommended that you take antibiotics prior to your dental treatment?	○ Yes ○ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No	Heart Stents	○ Yes ○ No				

Do you have any disease, condition, or problem not listed above that you think I should know about?	○ Yes ○ No	If yes	

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

DR. JOHN J. ROBERSON
WELCOME TO OUR PRACTICE

Please read over this document carefully. If you have any questions, please ask the receptionist before seeing the doctor.

OFFICE POLICY

If you have insurance, we will be happy to file on your behalf. All deductibles and co-payments are due at the time services are rendered. We are not a PPO practice, and do not sign up on PPO plans. If your insurance does not pay out of network dentists, you will be required to pay your bill in full at the time of service. We will file your claim and have your insurance reimburse you for the expense. All insurance claims not paid within 45 days from the date filed, become your responsibility. All charges not covered by insurance are the patient's responsibility. We do not offer an in-office payment plan. If you do not have insurance, payment in full is required at the time of service. We are set up to accept CASH, CHECKS, CHECK CARDS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CARE-CREDIT. If past due accounts are not paid within 90 days, we reserve the right to use your information to turn your account over to our collection agency. **WE DO NOT OFFER ANY IN-HOUSE BILLING OPTIONS.**

The doctor asks that all questions concerning your account be addressed to the billing office.

POLICY FOR FAILING TO KEEP SCHEDULED APPOINTMENTS

A $35 fee will be charged for all appointments broken without a 24-hour prior notice given. Please help us by letting us know when you are unable to keep your scheduled appointments, as others may want your appointment time. You may leave us a message on our voice mail to cancel appointments.

Please sign below stating that you have read and understand the policies of this office.

_____	_____
Patient Signature	Signature of guardian/responsible party
_____	_____
Date	Date
_____	_____
Print name	Print name

John J. Roberson, DDS
814 HIGHWAY 139 | MONROE LA, 71203 | (318) 343-2633

Written Financial Policy

Thank you for choosing John J. Roberson, DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Our office accepts:

- Cash or check, Visa®, MasterCard®, American Express® or Discover Card®
- Special financing options with convenient monthly payments available with the CareCredit healthcare credit card[1]
    - Allow you to pay over time
    - No annual fee[3]

Please note:

If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Payment Options:
We accept payment in thirds for treatments over $500. For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

John J. Roberson, DDS charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]CareCredit is a credit card offered by Synchrony Bank and is NOT an in-house credit program offered by John J. Roberson, DDS or any other healthcare provider. You may apply for the CareCredit healthcare credit card and if approved, use it at John J. Roberson, DDS's office. However the CareCredit credit card agreement is between you and Synchrony Bank. Subject to credit approval.

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

[3]For new accounts: Purchase APR is 26.99%; Minimum Interest Charge is $2. Existing cardholders should see their credit card agreements for their applicable terms. Subject to credit approval.

INSURANCE INFORMATION

Is patient covered under dental insurance? Yes No

If YES, Please list policy holder's information:

Name (exactly as it appears on card):_____
Date of birth of policy holder:_____
Social Security number or Member ID number:_____
Place of Employment:_____
Employer's Address_____
_____
Employer's Phone Number:_____
Relationship To Patient:_____

Insurance Company:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone: #_____
Group Number:_____

ADDITIONAL DENTAL INSURANCE? Yes No

Name (exactly as it appears on card):_____
Date of birth of policy holder:_____
Social Security number or Member ID number:_____
Place of Employment:_____
Employer's Address_____
_____
Employer's Phone Number:_____
Relationship To Patient:_____

Insurance Company:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone: #_____
Group Number:_____

WILL MY INSURANCE PAY FOR THIS?

We are happy to verify, ESTIMATE your portion of treatment costs, and file your insurance claims for you. However, we DO encourage our patients to be "savvy" consumers and know their insurance plans as well! Here are some *important things to know*.....

*Employers offer dental benefits to help employees pay for a PORTION of the cost of their dental care. The amount your plan pays is determined by the agreement negotiated by your employer with the insurer. Your plans "allowed" fees are the maximum amounts that will be covered by the plan for eligible services. The plan pays an established percentage of the dentist's fee or their "allowed" amount, whichever is less. (Exceeding the plan's "allowed" fee does NOT mean that your dentist has overcharged for the procedure.)

*Information needed to submit claims on your behalf include: insurance company name, group number, who the plan holder is, their member/subscriber ID or social security number, date of birth, employer, and the effective date of coverage.

*What your annual deductible and maximum benefits are per benefit period. Keep track of what you are using - once you have used the maximum dollar amount your plan will pay toward your dental care, you are responsible for costs incurred over that amount. The deductible is the amount you must pay out of pocket before your insurance company will start paying.

*Frequency Limitations are the number of times in a benefit period a procedure will be paid for by your plan. For instance, a fluoride treatment for your child may be covered only 1 time per year, while the ADA recommendation is 2 times per year.

* Any Exclusions or Waiting Periods which the consumer should be aware of. For example, a "missing tooth clause" means that the plan will not pay for ANY procedure to replace a tooth that was missing prior to the plans effective date.

*Cost Control Measures to keep their costs down may include:
Downcoding. For example, your dentist recommends a white composite filling on a molar, but your insurance will only pay for the silver amalgam filling. This is also known as "least expensive alternative treatment." It does not mean we "coded wrong" on the claim....we code exactly what we do. It is just another way your insurance company is saving money for themselves.
Bundling. An example of bundling is when periodic (check-up) exams and limited (emergency) exams are combined in the frequency limitation.
Remember, insurance companies DO NOT base their coverage on the American Dental Association's recommendations for optimal dental health.

CONSENT TO PERFORM DENTISTRY

Dr. John J. Roberson, D.D.S.
814 Highway 139
Monroe, LA 71203
(318) 343-2633

Patient's Name _____
Guardian's Name _____
Date _____

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PEASE ASK YOUR DOCTOR BEFORE INITIALING. THIS DOCUMENT GIVES AUTHORIZATION TO PREFORM NECESSARY DENTAL TREATMENT RECOMMENDED BY THE DOCTOR AND STAFF.

1. _____ TREATMENT:
   I understand that I may have the following dental treatment performed: Fillings, Crowns, Bridges, Removable Appliances, Extractions, Impacted tooth removal, Root Canals, treatment of periodontal disease, Whitening, Splint therapy or other work deemed necessary.
2. _____DRUGS AND MEDICATIONS:
   I understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.
3. _____ RISK OF DENTAL ANESTHESIA:
   I understand that pain, bruising, and occasional temporary or sometimes-permanent numbness in lips, cheeks, tongue or associated facial structure can occur with injections. About 99% of these cases revolve themselves in less than 8 weeks. Although very rarely needed, a referral to a specialist for evaluation and possibly treatment may be needed if the symptoms do not resolve.
4. _____HYGIENE AND PREVENTATIVE:
   I understand that it is the duty of the hygienist to need diagnostic x-rays in order for the dentist to properly diagnose treatment. If I refuse the x-rays I understand that I cannot hold the dentist, hygienist, or staff responsible for failure to diagnose any dental condition. I also understand that due to periodontal disease, gum infection, or failure to have my teeth cleaned and examined in a reasonable time; a more extensive appointment with the hygienist may be required and that my insurance may not pay the complete fee. I understand that any additional fee will be my responsibility to pay.
5. _____ FILLINGS:
   I understand that a more extensive restoration that originally planned, or possibly root canal therapy, may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration and usually subside in 1 to 2 weeks. It is my responsibility to inform the doctor is symptoms do not improve so that the required steps can be taken to resolve the discomfort. I also understand that the doctor uses "tooth-colored fillings" when doing restorations and it is my responsibility to pay the balance if my insurance does not cover this procedure in full.
6. _____ CROWNS, BRIDGES, INLAYS AND ONLAYS:
   I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth and further costs may be involved if custom shading is required. I further

understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. It is my responsibility to return within 6 weeks of tooth preparation for final cementation of the restoration. I understand that I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

7. _____ REMOVABLE PROSTHETICS:

I understand that choosing to wear dentures/partials is a decision made by me and I do not want to restore my teeth with recommended treatment by the doctor or the doctor has informed me that dentures/partials are my only option so that I may maintain good oral health. I also understand that, while I will no longer suffer from dental decay or infection, I could experience denture related problems such as shrinking bone and gums, poor chewing ability, altered speech, reduced taste and constant denture movement. Most denture wearers adjust to these symptoms quickly while others take time, and there are a few patients who do not manage well.

Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustments and one or more temporary relines within several months. I understand that failure to keep appointments may result in a less than desirable outcome. I understand that I must get my permanent reline when the doctor advises me it is time (usually this is within 9 months) or additional fees may be incurred.

8. _____ EXTRACTIONS:

Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. I have been advised of my treatment options but choose to go forth with an extraction. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risk of removing teeth include, but are not limited to; pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip or other facial areas, cheek, tongue, gums, and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw where the risks of removing it outweigh the benefits. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility. I acknowledge that I have been given a copy of the possible complications involved and that any questions I have pertaining to extractions have been answered.

9. _____ PERIODONTAL DISEASE:

Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instructions, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

10. _____ ROOT CANAL THERAPY:

I realize root canal therapy has a very high success rate, however, there is no guarantee that root canal treatment will save a tooth, and complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include; extensive decay making the tooth unrestorable, perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistent pain and infection. I understand that root

canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not cause success. Teeth exhibiting extensive infection where conventional root canal therapy is not enough might need further surgery or treatment by a specialist at additional costs to me. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if some complications arise, and any costs incurred are my responsibility. After root canal therapy, a crown is recommended to complete the permanent restoration of the tooth which, if not placed within the recommended time by the doctor, might lead to fracturing of the tooth and possible extraction retreatment of root canal. I acknowledge that I have been given a copy of possible complications that can arise during a root canal procedure.

11. _____ IN-OFFICE OR AT HOME WHITENING:
I understand that this is a cosmetic procedure and I must have a complete hygiene check-up and be free from tooth decay before proceeding with this treatment. I have been explained any complications such as tooth sensitivity, soreness of gums, ulcer or burn from the bleaching gel. I also understand that I may not reach my desired whiteness due to deep staining of my teeth, smoking, or intake of large amounts of staining beverages. I acknowledge that I have been given written home care instructions and an questions have been answered to my satisfaction.

12. _____ CHANGES IN TREATMENT PLAN:
I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgement to provide appropriate care. I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantee have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees are proposed are subjected to modifications, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by my doctor. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risk and complications associated with the treatment. I hereby give my consent for the treatment I have chosen.

Date:_____ Time:_____AM/PM

Patient's Name:_____

Name of Parent or Guardian:_____

Relationship to Patient:_____

_____

Signature Patient or Parent or Guardian

JOHN J. ROBERSON, D.D.S.
814 HWY 139
MONROE, LOUISIANA 71203
TELEPHONE: (318) 343-2633

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Birthdate:_____

Signature:_____ Date:_____

Relationship to patient:_____

CONSENT

I hereby authorize Dr. Roberson and/or members of his staff to release the personal health information:

1) Dental Services claims information
2) Prescriptions, diagnostic, treatment, and/or care management services
3) Communications from the dental office by telephone, email, fax, Postal service or any other means that the office feels efficient to contact me regarding the above mentioned statements

Signature of patient:_____ Date:_____

If there are other person or entities that your would like us to be able to speak to about your care, please list below:

_____ _____

_____ _____