

NORTHERN KENTUCKY ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES P.S.C.
MICHAEL L. ROBINSON, M.D., D.M.D., F.A.C.S.
HANK W. SLEET, M.D., D.M.D.

PATIENT INFORMATION

NAME _____ SS# _____ DATE OF BIRTH _____ AGE _____ SEX _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOME PHONE # _____ WORK# _____ OTHER # _____
 EMPLOYER _____ OCCUPATION _____
 PHYSICIAN _____ DENTIST _____ REFERRED BY _____

If student, name and address of school _____
 College students must provide a current school schedule.

- | | |
|---|---|
| 1. _____ Allergy to drugs or medication _____ | 9. _____ Allergies or asthma _____ |
| 2. _____ Taking medication regularly _____ | 10. _____ Diabetes _____ |
| 3. _____ _____ | 11. _____ Epilepsy or seizure disorder _____ |
| 3. _____ Presently under care of physician _____ | 12. _____ Hepatitis or liver disease _____ |
| 4. _____ Excessive bleeding, which required special treatment _____ | 13. _____ HIV disease _____ |
| 5. _____ Heart disease/mitral valve prolapse _____ | 14. _____ Nervous or emotional disorder _____ |
| 6. _____ Rheumatic fever _____ | 15. _____ Women, are you pregnant? _____ |
| 7. _____ High blood pressure or stroke _____ | 16. _____ If visit is due to injury, date of injury _____ |
| 8. _____ Breathing disorder, short of breath or cough _____ | 17. _____ Do you use tobacco products? _____ |

In case of emergency _____ Phone# _____

SPOUSE OR PARENT INFORMATION *(For insurance or billing purposes)*

NAME _____ SS# _____ DATE OF BIRTH _____ AGE _____ SEX _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOME PHONE # _____ WORK# _____ OTHER # _____

INSURANCE INFORMATION

	Dental Insurance	Medical/Surgical Insurance
Insurance Company	_____	_____
Address	_____	_____
Insured's Name	_____	_____
Employer	_____	_____
Group#	_____	_____
ID# or SS#	_____	_____

I authorize the release of any information relating to my treatment. I understand that I am responsible for all costs of treatment. I hereby authorize payment of group insurance benefits otherwise payable to me to be paid directly to Northern Kentucky Oral and Maxillofacial Surgery Associates P.S.C.

SIGNED: _____ DATE: _____
If under 18 years of age parent or guardian must sign.

