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

HEALTH HISTORY & PHYSICAL

RADIOLOGY:

DIAGNOSIS:

TREATMENT RECORD