DONALDROBBINS DMD, LLC DMD, FAGD, FIAOMT BIOSAFEDENTISTRY
PROTECTING YOUR HEALTH

Welcome to our practice! Enclosed please find the forms new patients need to complete. Please complete the forms *before* the day of your visit and ***bring them with you or (e)mail them to us (filled out completely)*** for your first visit. This will allow us to start your *appointment on time*. In addition, please bring your insurance information and booklet so our front desk staff can assist you in the proper submittal of your claims.

Dr. Robbins has been practicing dentistry in the Exton area for over 30 years. He emphasizes preventative care and restorative and cosmetic procedures in a clean, healthy manner (BioSafeDentistry dentistry).

Your 1st visit allows you to meet Dr. Robbins immediately. He will sit down with you and discuss your concerns, reviewing both your medical and dental history. Because our practice is designed to help you improve your health in many ways (just not your teeth), Dr. Robbins will review some of the BIOSAFEDENTISTRY factors that may be beneficial to your treatment. Discussions include toxic materials, such as mercury, fluoride, nickel and other non-biocompatible materials that may damage your health and suggestions for specific nutritional supplements that may improve your overall health. You will have a full examination performed, and intraoral photographs as well as digital radiographs (x-rays) will be taken (if needed).

Your 2nd visit will address your hygiene needs with our hygienist Lori who will digitally chart your gum levels, clean, scale and polish your teeth (all without fluoride) and make recommendations for oral care procedures and products to help you maintain your dental health. If you need dental treatment, additional time is allotted after your hygiene time to consult with Dr. Robbins. Nina, our office manager will also discuss appointments, fees, payment options and any insurance coverage questions you may have.

We have an open door policy. Any time you have a question or are unsure about any appointment, treatment, fee or office procedure, you are encouraged to discuss it with us promptly and openly. You will always be told in advance, when making an appointment, what your charges for that visit will be.

We thank you in advance for **refraining from the use of any perfume or cologne** for any of your visits due to the sensitivities many of our patients have.

We look forward to meeting you and welcome you to our dental family! Please visit our website at www.donaldrobbinsdmd.com prior to your first appointment to learn more about our office and BioSafeDentistry (www.biosafedentistry.com).

340 North Pottstown Pike (Route 100), P.O. Box 449, Exton, PA 19341
Tel: 610-363-1980, Fax: 610-363-7798, drrobbins@donaldrobbinsdmd.com, www.donaldrobbinsdmd.com

WELCOME TO THE OFFICE OF DR. DONALD ROBBINS

Get Acquainted Form

340 N. Pottstown Pike, P.O. Box 449
Exton, PA 19341
610-363-1980

PERSONAL INFORMATION

Patient Name _____
LAST FIRST MIDDLE

Birth Date _____ Social Security Number _____

Home Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Cell _____ Work _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Home E-Mail Address: _____

Work E-Mail Address: _____

SPOUSE (OR PARENT) INFORMATION

Spouse/Parent Name _____
LAST FIRST MIDDLE

Birth Date _____ Social Security Number _____

Home Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Cell _____

Work _____ Ext _____

Employer _____ Occupation _____

Business Address _____ City, State, Zip _____

Do you have Children? (Names & ages): _____

INSURANCE INFORMATION

Patient Dental Insurance Company _____ Group # _____

Policy # _____ Telephone _____

Spouse Dental Insurance Company _____ Group # _____

Policy # _____ Telephone _____

Previous Medical/Dental Information

MEDICAL Physician Name _____ City/State _____

Date of Last Medical Visit _____ Reason _____

DENTAL Dentist Name _____ City/State _____

Date of Last Visit _____ Reason _____

Date of Last Complete Series X-rays: _____

Why did you leave your last dentist? _____

Past /Present Medical History

Rheumatic Fever	Y N	Hepatitis	Y N	**ALLERGIES:**	
Heart Valve Replace	Y N	Aids/Immune		Penicillin	Y N
Mitral Valve Prolapse		Disease	Y N	Erythromycin	Y N
MVP	Y N	Convulsions	Y N	Clindamycin	Y N
Pacemaker	Y N	Lung/Liver/Kidney		Tetracycline	Y N
High Blood Pressure	Y N	Disease	Y N	Sulfa Drugs	Y N
Heart/Chest Pain	Y N	Diabetes	Y N	Codeine	Y N
Bleeding Tendency	Y N	Asthma or		Aspirin/Tylenol	Y N
Heart Attack/Stroke	Y N	Bronchitis	Y N	Fruits or Flavors	Y N
Ever been chemically		Anemia	Y N	Latex	Y N
dependent?	Y N	Joint Replacement?	Y N	Cancer	Y N

How did you find out about our office? _____

Are you currently pregnant or nursing?.....Y N

Do you need to PREMEDICATE with antibiotics before dental treatment?.....Y N

Do you smoke?.....Y N ⟶ If yes how much?..... _____/day

Do you get Herpes lesions (cold sores)?.....Y N If yes how often per year? _____

Are you being treated by a physician now?.....Y N

If yes for what condition? _____

List any medications you are now taking (list medication and reason for taking)

_____

_____

_____

Do you like your smile? ....Y N What would you change if possible? _____

_____

Are you aware of the health dangers of mercury? **Y N**

Are you aware of the dangers of fluoride? **Y N**

Are you concerned about the mercury fillings in your mouth? **Y N**

Would you like us to send a report of our dental findings to any healthcare provider? **Y N**

If yes to the above question, please provide us with that provider(s) name and address (below).

_____

_____

_____

I consent to necessary treatment by Dr. Robbins, as it will be explained to me, along with possible side effects, in advance. I understand that regardless of my insurance coverage, I am financially responsible to Dr. Robbins for my account. I understand there may be a charge for appointments missed or cancelled by me without 48-hour advance notice, unless my allotted time can be appointed to another patient. I permit Dr. Donald Robbins, D.M.D. to release my records, as may be necessary to physicians, dentists, attorneys, other health care providers and insurance companies involved in my health care.

DATE: _____ SIGNATURE: _____

(AT NEXTCHECKUP) I have reviewed this form. There are no changes to my health at this time.

DATE: _____ SIGNATURE: _____

FOR DENTAL STAFF ONLY

I have reviewed this form with the patient and have initialed below

DATE/REVIEWER

_____ _____

_____ _____

_____ _____

_____ _____

DONALDROBBINS DMD, LLC
DMD, FAGD, AIAOMT
BIOSAFE DENTISTRY
PROTECTING YOUR HEALTH

PATIENT SUPPLEMENTS LIST

Patient Name: _____ Date: _____

Supplement	Brand	Taken How Often?	Dosage	Reason for taking

It is important to complete this form with precise dosage and brand for your initial consultation with Dr. Robbins

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DONALD ROBBINS DMD, LLC
BMD, FAGD, FAC
BIOSAFE DENTIS
PROTECTING YOUR HEALT

APPOINTMENT CANCELLATION POLICY and CONFIRMATION SYSTEM

Cancellation Policy

Every patient is carefully scheduled in order to allow the necessary time to complete their treatment and to provide the quality experience and care we are proud to provide. There are times that my patients require urgent or emergency treatment, and therefore require an appointment as soon as possible. Unfortunately, many offices overbook their schedule expecting that a few patients will not keep their appointment. We do not schedule our patients in this fashion. Your appointment time has been reserved specifically for you! Therefore, if you cannot keep your appointment, we ask you give appropriate advance notice. This time can then be allocated to those patients in urgent need of treatment.

We ask for a minimum of 2 business days notice if your appointment must be changed or cancelled. In the event notice is not given, or, if you do not show for your appointment, you will be billed a broken appointment fee ($45 per hour for hygiene appointments and $100 per hour for doctor appointments). Please note if you have scheduled multiple family member appointments and cancel less then 48 hours in advance , a broken appointment fee will be charged for each family member. ***It is our wish to never have to charge a patient for broken appointments and that each patient understands this critical aspect of our relationship and its importance.***

Confirmation System

- Fourteen days prior to your appointment you will receive a "save the date" email or text (if you have provided us with your cell phone number and/or email address) reminding you your appointment is upcoming. If you need to reschedule your appointment please call and do so at this time.

- Five days in advance of the appointment an automated reminder is sent via email or text message. You should confirm your appointment at this time.

- One to two business days prior to your appointment, we will call to confirm your appointment and if we do not speak with you personally, we will ask for a return call. **Note: It is important for you to return this call or your appointment may be given to another patient.**

We value the relationship we have with you! Our entire team is dedicated to providing you with the highest level of care. If you have questions or concerns about any of the above, please contact our office and speak with one of our office staff.

_____ _____

Patient Signature Date