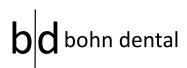


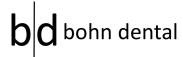
New Patient Information

				MOFO	
Full Legal Name		Date of Birth		Sex	
		SINGLEOMARRIEDO			
Social Security Number		(Please circle)			
Address					
E-mail Address		Home Telephone	Cell	Work Telephone	
Emergency Contact Name & Relationship		Emergency Contact Te	Emergency Contact Telephone Number		
Name of person respon	sible for your dental account	If different from above in	formation please	provide telephone number	
	Primary I	nsurance Informatio	n		
Subscriber Name					
Birth Date of Insured	SS# or ID of Insured	Home Telephone		Cell Phone	
Address if different from	patient	Employer of Insured			
Insurance Company		Group#/ID#			
	Secondary	Insurance Informati	ion		
Subscriber Name		Relationship to Patien	t		
Birth Date of Insured	SS# or ID of Insured	Home Telephone		Cell Phone	
Address if different from	patient	Employer of Insured			
Insurance Company		Group#/ID#			



Medical History Form

Patient Name:		Emerger	ncy Contact		
Date of Birth:		Emerger	ncy Contact Phone		
Sex:	Male Female	Emerger	ncy Contact Relationship		
Oo you have any of	the following diseases or problems	-			
				Ves	No
					○ No
					○ No
					No
Medical History				0103	ONO
-	e care of a physician?			OVee	ONe
Physician Name				res	○ No
Phone (including are	ea code)				
	/Zip				
				Ov	
					O No
	on is being treated?			Yes	No
	l exam				
				Yes	○ No
•	· -		(10)		
	e you recently taken any prescription or over the c including vitamins, natural or herbal preparations		e(s)?	Yes	No
ii so, piease iist aii, i	ncidaling vitatilins, natural of herbal preparations	and/or diet sup	pienents		
Do you wear contact le	enses?			Ov	O N -
			eplacement?		O No
	,			Yes	No
·	any complications?				
			samax®) or risedronate (Actonel®) for osteoporosis or	Yes	○ No
•	treated or are you presently scheduled to begin tr	eatment with th	ne intravenous biphosphonates (Aredia® or Zometa®) for	Yes	○ No
bone pain, hypercalce Date Treatment beg	mia or skeletal complications resulting from Paga an	et's disease, mu	ultiple myeloma or metastatic cancer?) ics	ONO
Do you use controlled	substances (drugs)?			Yes	No
Do you use tobacco (smoking, snuff, chew, bidis)?					No
Do you drink alcoholic	beverages?			Yes	No
If yes, how much do					
NOMEN ONLY. Are	•				
				Yes	No
Taking birth control pi	lls or hormonal replacement?			Yes	○ No
Nursing?				Yes	○ No
Allergies, Are you a	llergic to or have you had any reaction	n to			
Local anesthetics	Yes	No	Sulfa drugs	Yes	No
Aspirin	Yes	No	Codeine or other narcotics	Yes	No
Penicillin or other anti	bioticsYes	No	Metals	Yes	No
Barbiturates, sedatives	s, or sleeping pillsYes	No	Latex (rubber)	Yes	No



lodine Yes	○No	Other Yes	○ No
Hay fever/seasonalYes	No	If Other, please specify:	
AnimalsYes	No		
FoodYes	No		
Congenital Heart Disease (CHD) - Please indicate if you	have had or	not had any of the following:	
Artificial (prosthetic) heart valveYes	No	Congenital heart disease (CHD)Yes	○ No
Previous infective endocarditisYes	No	Unrepaired, cyanotic CHD Yes	○ No
Damaged valves in transplanted heartYes	No	Repaired (completely) in the last 6 months Yes	○ No
	0.10	Repaired CHD with residual defectsYes	○ No
Other Diseases and Conditions - Please indicate if you h	nave had or n		
Cardiovascular diseaseYes	No	Cancer/Chemotherapy/Radiation TreatmentYes	○ No
Angina Yes	No	Chest pain upon exertionYes	○ No
ArteriosclerosisYes	_	Chronic painYes	○ No
Congestive heart failure	O No	Diabetes Type I or IIYes	
	No	Eating disorderYes	O No
Damaged heart valvesYes	No		O No
Heart attackYes	No	MalnutritionYes	○ No
Heart murmurYes	No	Gastrointestinal diseaseYes	○ No
Low blood pressureYes	No	G.E. Reflux/persistent heartburnYes	○ No
High blood pressureYes	No	Thyroid problemsYes	○ No
Other congenital heart defectsYes	No	StrokeYes	○ No
Mitral valve prolapse Yes	No	GlaucomaYes	○ No
PacemakerYes	No	Hepatitis, jaundice or liver disease Yes	○ No
Rheumatic fever Yes	No	EpilepsyYes	○ No
Rheumatic heart diseaseYes	No	Fainting spells or seizuresYes	○ No
Abnormal bleedingYes	No	Neurological disordersYes	○ No
AnemiaYes	No	If yes, please specify	
Blood transfusionYes	No	Sleep disorderYes	○ No
If yes, date		Mental health disordersYes	○ No
HemophiliaYes	No	Specify	
AIDS or HIVYes	No	Recurrent infectionsYes	○ No
ArthritisYes	No	Type of infection	
Autoimmune diseaseYes	○ No	Kidney problemsYes	○ No
Rheumatoid arthritis Yes	O No	Night sweatsYes	○ No
Systemic lupus erythematosus Yes	No	OsteoporosisYes	
Asthma Yes		Persistent swollen glands in neck Yes	O No
BronchitisYes	O No	Severe headaches/migraines	○ No
	No		○ No
EmphysemaYes	No	Severe or rapid weight lossYes	○ No
Sinus trouble Yes	No	Sexually transmitted diseaseYes	O No
TuberculosisYes	No	Excessive urinationYes	○ No
Premedication			
		our dental treatment?	0
Name of physician or dentist making recommendation (include pho	′ –		
Do you have any disease, condition, or problem not listed above that	you think I shoul	d know about?	01
Please explain			

No-Show	/Cancel	lation	Po	lic\	/:
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We urge you to keep your appointments, due to limited time and space. We understand that emergencies can happen at any time, but we ask that you give us 48-hour notice if you need to reschedule or cancel your appointment. A broken appointment fee of \$40 will be assessed on a case by case basis in the event of failure to provide adequate notice.

Initials

Financial Agreement:

All estimated co-pays are to be paid at the time of service. If you are unable to fulfill your financial responsibility, we do reserve the right not to render services at the scheduled appointment. Our office accepts cash, personal checks, MasterCard and Visa. If needed, outside financing is available

Initials

Assignment of Benefits:

Our office will accept assignment of benefits from your insurance company with the provisions listed below. It is important to understand the agreement 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 reimbursed by your insurance company. The following provisions identify our policies governing insurance claims:

- We will bill your insurance company as a courtesy with your consent as signed below.
- We require you pay the estimated portion not covered by your insurance company at the time we provide service to you.
- The portion that we estimate, is only an estimate which could result in an additional amount due after benefits have been paid to our office.
- Insurance is ordinarily received within 30-45 days from the time of billing. If your insurance company has not made payment to our office within 45 days, you will be responsible for the entire balance at that time. At that point you will be responsible for seeking reimbursement from your insurance company at that time.
- We do 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.
- We will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation if your insurance company requests to sort out any confusion or questions that may arise. 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 accept the terms and conditions of this assignment of benefits agreement. I authorize my insurance company to pay my dental benefits directly to Bohn Dental PLLC.

Initials

HIPAA/Patient Privacy Act:

The Health Insurance Portability and Accountability Act requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of HIPAA's requirements, we are offering to give you a copy of our Notice of Privacy Practices. This policy contains information that HIPAA requires us to disclose regarding our privacy practices.

We are also required to obtain your written consent and acknowledgement prior to disclosing any of your information except for our dis- closures in connection with: defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; court order as a part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

It may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide material to a laboratory or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

	-	
Patient Signature (Parent/Guardian if under 18)		Date

Please list any other person(s) that we may share your dental information with: