bohn dental

New Patient Information

Full Legal Name

Date of Birth

M F

Sex

Social Security Number

SINGLE MARRIED

(Please circle)

Address

E-mail Address

Home Telephone

Cell

Work Telephone

Emergency Contact Name & Relationship

Emergency Contact Telephone Number

Name of person responsible for your dental account

If different from above information please provide telephone number

Primary Insurance Information

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 Information

Subscriber Name

Relationship to Patient

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#

bohn dental

Medical History Form

Patient Name: _____

Date of Birth: _____

Sex: ◯ Male ◯ Female

Emergency Contact _____

Emergency Contact Phone _____

Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis ◯ Yes ◯ No

Persistent cough greater than a 3 week duration ◯ Yes ◯ No

Cough that produces blood ◯ Yes ◯ No

Been exposed to anyone with tuberculosis ◯ Yes ◯ No

Medical History

Are you now under the care of a physician? ◯ Yes ◯ No

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

Are you in good health? ◯ Yes ◯ No

Has there been any change in your general health within the past year? ◯ Yes ◯ No

If yes, what condition is being treated? _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ◯ Yes ◯ No

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ◯ Yes ◯ No

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

_____

Do you wear contact lenses? ◯ Yes ◯ No

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? ◯ Yes ◯ No

Date _____

If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ◯ Yes ◯ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ◯ Yes ◯ No

Date Treatment began _____

Do you use controlled substances (drugs)? ◯ Yes ◯ No

Do you use tobacco (smoking, snuff, chew, bidis)? ◯ Yes ◯ No

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____

Do you drink alcoholic beverages? ◯ Yes ◯ No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY. Are you:

Pregnant ◯ Yes ◯ No

Number of weeks _____

Taking birth control pills or hormonal replacement? ◯ Yes ◯ No

Nursing? ◯ Yes ◯ No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics ◯ Yes ◯ No

Aspirin ◯ Yes ◯ No

Penicillin or other antibiotics ◯ Yes ◯ No

Barbiturates, sedatives, or sleeping pills ◯ Yes ◯ No

Sulfa drugs ◯ Yes ◯ No

Codeine or other narcotics ◯ Yes ◯ No

Metals ◯ Yes ◯ No

Latex (rubber) ◯ Yes ◯ No

Iodine ..... Yes No

Hay fever/seasonal ..... Yes No

Animals ..... Yes No

Food ..... Yes No

Other ..... Yes No

If Other, please specify:

_____

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve ..... Yes No

Previous infective endocarditis ..... Yes No

Damaged valves in transplanted heart ..... Yes No

Congenital heart disease (CHD) ..... Yes No

Unrepaired, cyanotic CHD ..... Yes No

Repaired (completely) in the last 6 months ..... Yes No

Repaired CHD with residual defects ..... Yes No

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease ..... Yes No

Angina ..... Yes No

Arteriosclerosis ..... Yes No

Congestive heart failure ..... Yes No

Damaged heart valves ..... Yes No

Heart attack ..... Yes No

Heart murmur ..... Yes No

Low blood pressure ..... Yes No

High blood pressure ..... Yes No

Other congenital heart defects ..... Yes No

Mitral valve prolapse ..... Yes No

Pacemaker ..... Yes No

Rheumatic fever ..... Yes No

Rheumatic heart disease ..... Yes No

Abnormal bleeding ..... Yes No

Anemia ..... Yes No

Blood transfusion ..... Yes No

If yes, date _____

Hemophilia ..... Yes No

AIDS or HIV ..... Yes No

Arthritis ..... Yes No

Autoimmune disease ..... Yes No

Rheumatoid arthritis ..... Yes No

Systemic lupus erythematosus ..... Yes No

Asthma ..... Yes No

Bronchitis ..... Yes No

Emphysema ..... Yes No

Sinus trouble ..... Yes No

Tuberculosis ..... Yes No

Cancer/Chemotherapy/Radiation Treatment ..... Yes No

Chest pain upon exertion ..... Yes No

Chronic pain ..... Yes No

Diabetes Type I or II ..... Yes No

Eating disorder ..... Yes No

Malnutrition ..... Yes No

Gastrointestinal disease ..... Yes No

G.E. Reflux/persistent heartburn ..... Yes No

Thyroid problems ..... Yes No

Stroke ..... Yes No

Glaucoma ..... Yes No

Hepatitis, jaundice or liver disease ..... Yes No

Epilepsy ..... Yes No

Fainting spells or seizures ..... Yes No

Neurological disorders ..... Yes No

If yes, please specify _____

Sleep disorder ..... Yes No

Mental health disorders ..... Yes No

Specify _____

Recurrent infections ..... Yes No

Type of infection _____

Kidney problems ..... Yes No

Night sweats ..... Yes No

Osteoporosis ..... Yes No

Persistent swollen glands in neck ..... Yes No

Severe headaches/migraines ..... Yes No

Severe or rapid weight loss ..... Yes No

Sexually transmitted disease ..... Yes No

Excessive urination ..... Yes No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ..... Yes No

Name of physician or dentist making recommendation (include phone number) _____

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

Please explain _____

_____

Signature of Patient/Legal Guardian

No-Show/Cancellation Policy:

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:

_____