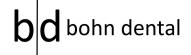


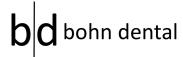
New Patient Information

				M O F O	
Full Legal Name		Date of Birth		Sex	
		SINGLE MARRIED			
Social Security Number		(Please circle)			
Address					
E-mail Address		Home Telephone	Cell	Work Telephone	
Emergency Contact Nam	e & 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 Ir	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#			

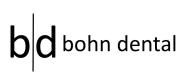


Medical History Form

Sec. Male Pernale Energetry Cottest Please Sec. Male Pernale Energetry Cottest Relationship Do you have any of the following diseases or problems Actual Laboraulation	Patient Name:		Emergenc	y Contact		
Do you have any of the following diseases or problems Addae-Tidercruleus- Addae-Tidercruleu	Date of Birth:		Emergenc	y Contact Phone		
Advanced from the control of the con	Sex: M	1ale Female	Emergenc	y Contact Relationship		
Besistent cough greatest than a 3 Aveel duration	Do you have any of the fo	ollowing diseases or problems				
Caugh that produces blood Yes No	Active.Tuberculosis				Yes	○ No
Medical History Medical History An oper accounted the case of polysticism? Physicism Name Phone (noturing area code) Address/City/State2p Address/City/State2p Address/City/State2p Address/City/State2p And pour large design in pass agreement health within the post year? If yes, what condition is being treated? Date of last physical exam Here you had a constant linears, operation or been hospitalized in the past year? If yes, what was the linear or problem? If yes, what was the linear or problem? As possed list all, including vitamins, natural or herbal preparations and/or diet supplements Do pay wear accordated foreacts. Do pay wear accordated foreacts. Are you laiding or scheduled to begin taking sister of the medications, alendromate (Fasamasch) or insedimente (Accordity) for cateoporous or Yess No Date If yes, who you had any complications? Are you laiding or scheduled to begin taking sister of the medications, alendromate (Fasamasch) or insedimente (Accordity) for cateoporous or Yess No Date If you, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aradialo or Zonatala) for Yess No Date pain, hyperrelacement sealesic complications returning from Pages; disease; Does Termient began Day you mittered the disopping? VERY / SOMEMAT / NOT INTERESTED Does Interment began How you interested in disopping? VERY / SOMEMAT / NOT INTERESTED WOMEN ONLY, Are you: Fragulation cannot pill for one medidology of disk in the last 24 hours? If yes, how much day you placely disk in a week? WOMEN ONLY, Are you: Fragulation cannot pill for one medidology of disk in the last 24 hours? If yes, how much day you placely disk in a week? No Date of the medidology of the medication requiring them Pages; disease; No Date of the medidology of the medication was all any reaction to Salfa drugs. No Date of the medidology of the medication was all any reaction to Salfa drugs. No Date of the medidology of the medication was all any reaction to Salfa drugs.	Persistent.cough.greater.than	r.a.3.week.duration			Yes	○ No
Medical History Are you now under tho care of a, physician? Physician Name Phone (including area code) AddressCrip(Sistant/II) Add you ta good Asabth? *** a year year year year year year year ye	Cough that produces blood	!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!			Yes	○ No
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Physician Name Phone (including area code) Address/Chy/Stack/20 Address/Chy/Stack/20 Asypois is agood bealth?	Medical History					
Phone (including area code) Address/Chy/State/Zip Address/Chy/State/Zip Address/Chy/State/Zip Yes No Hos-Arrayon is agend through the post page of the past to provide the past system Yes No Hyes, what condition is being treated? Yes No Hyes, what was the literace or problem? Yes No Hyes, what was the literace or problem? Yes No Hyes, please list all, including vitamins, natural or herbal preparations and/or diet supplements Yes No Joint Replacement. Have your had any exthopedic total joint (hip, knee, elbow, finger) replacement? Yes No Joint Replacement. Have your had any complications? Yes No Joint Replacement. Have your had any complications? Yes No Paget's disease? Yes No Paget's disease? Yes No Paget's disease? Yes No Done pain hyperaclemia or shelded to begin telaing entire of the medication, alendronate (Fosamax®) or risedonate (Actorate®) for osteophosis or Yes No Done pain hyperaclemia or shelded to begin telaing entire the high many complications? Yes No Done pain hyperaclemia or shelded to begin telaing entire them had not the high page of the paget disease, multiple myeloma or metastato cancer? Yes No Done pain hyperaclemia or shelded complications resulting from Paget's disease, multiple myeloma or metastato cancer? Yes No Boy su use cobasca (amoleng a multiple help being blight of the high page had not been been paged by the page had not been been been paged been paged by the page had not been been been paged by the page had not been been paged by the page had not been paged had not been paged had not been paged had not been paged by the page had not been paged had not been pag	Ara you now under the care o	f_a.physician?			Yes	○ No
Address/City/Sture/Zip Are you also agond shealth?	Physician Name				_	
Address/City/Sture/Zip Are you also agond shealth?	Phone (including area code	e)			_	
Alas thore-been any-change in your general health within the past year? Yes No If yes, what condition is being treated?						
Alas thore-been any-change in your general health within the past year? Yes No If yes, what condition is being treated?					- Ves	○ No
If yes, what condition is being treated? Date of last physical exam Attains you had a aerious allianes, operation or been hospitalized in the past 5 years? If yes, what was the fliances or problem? Are you sking on have you reaemby taken amy precription or over the counter medicine(s)? If so, please list all, including vitamines, natural or herbal preparations and/or diet supplements Do you weak opinists kenises? Yes No John Regissement - Nove you had any complications? Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for ostoopurosis or Pegers disease? Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous byhosphonates (ArediaS or Zometa®) for bore pain hypercaleomial or skeletal complexations resulting from Pagets disease, multiple myeloma or metistatic cancer? Date Treatment began Do you use controlled substances (Aregia)? Pege you use cloakese (emeking, ameri, chew, bids)? Yes No To you such obscess (emeking, ameri, chew, bids)? If yes, how much do you typically drink in a week? WOMEN ONLY. Are you: Yes No Allergies, Are you allergic to or have you had any reaction to Suifa drugs Yes No Codeine or other narcotics Yes No Codeine or other narcotics Yes No Metals Pencilifir or other anifoldices Yes No Metals Pencilifir or other anifoldices Yes No Metals						
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Memory out had a serious-illness, operation or been hospitalized in the past 5 years? Yes No If yes, what was the illness or problem? Yes No If yes, what was the illness or problem? Yes No If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements Yes No If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements Yes No Joint Replacement-Investors Yes No Joint Replacement-Investors Yes No Date If yes, have you had any complications? Yes No Pagets disease? Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actorel®) for osteoporosis or Yes No Pagets disease? Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for Yes No Date Treatment began Pagets disease, multiple myeloma or metastatic cancer? Yes No On you use tobsease (amoking,-erreff; chees, bidig? Yes No On you use tobsease (amoking,-erreff; chees, bidig? Yes No If yes, how much alcohol did you drink in the last 24 hours? Yes No Number of you keeks Yes No Number of you was altergic to or have you had any reaction to Yes No Number of you was altergic to or have you had any reaction to Yes No Number of you was altergic to or have you had any reaction to Yes No Number of your probability Yes No Number of you	Date of last physical exam	<u></u>				
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Do you wear-contact-fersees?					Yes	○ No
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Date						
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Latex (rubber)			No	Codeine or other narcotics	Yes	No
Latex (rubber) Barbitorates; sedatives; or sleeping pills: Yes No Latex (rubber)			No	Metals	Yes	No
	Barbiturates; sedatives, or sle	reping pills Yes No	No	Latex (rubber)	Yes	○ No



y fever/seasonal	Congenital heart disease (CHD) Yes Unrepaired, cyanotic CHD Yes Repaired (completely) in the last 6 months Yes Repaired CHD with residual defects Yes
penital Heart Disease (CHD) - Please indicate if you have had or difficial (prosthetic) heart valve	Congenital heart disease (CHD) Yes Unrepaired, cyanotic CHD Yes Repaired (completely) in the last 6 months Yes Repaired CHD with residual defects Yes not had any of the following:
genital Heart Disease (CHD) - Please indicate if you have had on tificial (prosthetic) heart valve Yes No evious infective endocarditis Yes No maged valves in transplanted heart Yes No er Diseases and Conditions - Please indicate if you have had or rdiovascular disease Yes No Yes No egina Yes No	Congenital heart disease (CHD) Yes Unrepaired, cyanotic CHD Yes Repaired (completely) in the last 6 months Yes Repaired CHD with residual defects Yes not had any of the following:
evious infective endocarditis	Congenital heart disease (CHD) Yes Unrepaired, cyanotic CHD Yes Repaired (completely) in the last 6 months Yes Repaired CHD with residual defects Yes not had any of the following:
evious infective endocarditis	Unrepaired, cyanotic CHD Yes Repaired (completely) in the last 6 months Yes Repaired CHD with residual defects Yes not had any of the following:
er Diseases and Conditions - Please indicate if you have had or rdiovascular disease	Repaired (completely) in the last 6 months Yes Repaired CHD with residual defects Yes not had any of the following:
er Diseases and Conditions - Please indicate if you have had or rdiovascular disease	Repaired (completely) in the last 6 months Yes Repaired CHD with residual defects Yes not had any of the following:
er Diseases and Conditions - Please indicate if you have had or rdiovascular disease	not had any of the following:
rdiovascular disease	not had any of the following:
rdiovascular disease	
ginaYes No	
	Chest pain upon exertionYes
	Chronic painYes
ngestive heart failure	Diabetes Type I or II
	Eating disorderYes
	Malnutrition Yes
	Gastrointestinal disease
art murmur Yes No	G.E. Reflux/persistent heartburnYes
w blood pressure	
gh blood pressureYes No	Thyroid problemsYes
ner congenital heart defects	StrokeYes
tral valve prolapseYes No	GlaucomaYes
cemakerYes No	Hepatitis, jaundice or liver diseaseYes
eumatic fever Yes No	EpilepsyYes
eumatic heart diseaseYes No	Fainting spells or seizuresYes
normal bleedingYes No	Neurological disordersYes
emiaYes No	If yes, please specify
ood transfusion	Sleep disorderYes
f yes, date	Mental health disordersYes
mophiliaYes No	Specify
OS or HIVYes No	Recurrent infectionsYes
thritisYes No	Type of infection
toimmune diseaseYes No	Kidney problemsYes
eumatoid arthritisYes No	Night sweatsYes
stemic lupus erythematosusYes No	OsteoporosisYes
thmaYes No	Persistent swollen glands in neckYes
onchitisYes No	Severe headaches/migraines Yes
nphysemaYes No	Severe or rapid weight lossYes
nus trouble	Sexually transmitted diseaseYes
hamalada e	
	Excessive urinationYes
nedication	-
s a physician or previous dentist recommended that you take antibiotics prior to value of physician or dentist making recommendation (include phone number)	your delital treatment?Yes



DENTAL HISTORY						
Reason for your visit today?						
Previous Dentist (Name and Location):						
How often do you brush your teeth	1?		How often do you floss your teeth?			
Is your drinking water fluoridated?	YES O	NO O	Do you have pain in any of your teeth?	YES O	NO ()	
Do your gums bleed when brushing or flossing?	YES 🔘	ио О	Do you experience jaw clicking?	YES O	оо О	
Are your teeth sensitive to cold?	YES 🔘	ио 🔘	Do you experience jaw pain?	YES (NO 🔘	
Are your teeth sensitive to hot?	YES O	NO O	Do you experience difficulty opening or closing?	YES O	NO ()	
Are your teeth sensitive to sweet?	YES 🔘	NO O	Do you have difficulty chewing?	YES ()	№ О	
Do you use a CPAP machine?	YES O	NO O	Do you bite your lips or cheeks frequently?	YES O	NO ()	
Do you clench or grind your teeth?	YES O	ио О	Have you noticed loosening of your teeth?	YES 🔘	№ О	
Does food tend to become caught between your teeth?	YES 🔘	NO O	Have you had difficult teeth extractions in the past?	YES (NO ()	
Have you had periodontal gum treatment?	YES 🔘	NO O	Have you ever had any prolonged bleeding following extractions?	YES (№ О	
Have you worn a bite guard or other dental appliance?	YES 🔘	NO O	Do you wear dentures or partials?	YES O	№ О	
Is there anything about your smile you would like to change? YES NO NO Explain, if yes:						

No-Show,	/Cancel	lation	Policy	V:
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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: