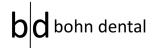


3686 32nd Avenue Suite 100 Hudsonville, MI 49426 office@bohn-dental.com www.bohn-dental.com 616.425.8892

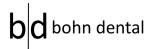
New Patient Information

Full Legal Name:		Date of Birth:			
Preferred Name and/or Nickname:					
Cell Phone Number:	Street Address:				
Home Phone Number:	Apartment #:	Apartment #:			
Email Address:	City, State, Zip:	, MI,			
Job Title:	Employer:				
How did yo	ou hear about our office? (pled	ase check below)			
☐ I was referred by	, a 🗆	Ifriend □family member □co-worker			
☐ Google ☐ P	ostcard 🗆 Bohn Do	ental Website Office Location			
☐ Facebook/Instagram ☐ N	∕lagazine □ Insuran	ce Company 🗆 In-Person Event			
<u>D</u> (ental Insurance Inforn	<u>nation</u>			
Insurance Company:		Group/Plan #:			
Do you have a Secondary Insurance Polic	y? (please circle) YES N	NO			
* Please provide the following info	rmation <u>ONLY IF</u> the subscriber/poli	cy holder is <u>different</u> than person above *			
Subscriber/Policy Holder Name:		Date of Birth:			
Subscriber's Employer:		Social Security #:			
<u>Financia</u>	l Responsibility and Assignme	nt of Benefits:			
understand your obligation is to pay for treatmer	nt in full, regardless of the amount to be collected at time of service but a	wever, all co-pays are estimated. It is important to hat may or may not be reimbursed by your insurance n additional amount due could come as a statement to			
We will bill your insurance company as a courtesy payment within 90 days, you will be responsible f		w). If your insurance company has not remitted eek reimbursement from your insurance company.			
If you are unable to fulfill your financial responsik	pility for a service, we do reserve the	e right to not perform the service.			
	ectly to Bohn Dental PLLC and will in	is assignment of benefits agreement. I authorize my inform them of any changes to my insurance policy. I re/treatment is my personal responsibility.			
Responsible Party Signature:		Date:			



TUBERCULOSIS CHECK

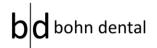
Please check if you have had any of the following diseas Active Tuberculosis Been Exposed to anyone with Tuberculosis			Persistent cough lasting more than 3 weeks
GENERAL HEALTH INFORMATION			
Preferred Pharmacy:	Phone	e:	Street/City:
Medical Emergency Contact:	_ Phon	e:	Relationship:
Primary Care Physician:	Phon	e:	Location:
Please check "YES" or "NO" to the following hea	Ith que	estions	s and provide additional details as needed
Question	NO	YES	OTHER/NOTE:
Are you in Good Health?			Please provide month/year of last exam:
In the past year, have there been any changes in your health?			If yes, please note condition being treated:
In the past 5 years, have you been hospitalized for a serious illness or operation?			If yes, please provide details of illness or surgery:
Are you currently taking any prescription or over the counter medicines/vitamins/supplements?			If yes, please list all:
Do you wear contact lenses?			
Have you had any orthopedic total joint replacement? (Including hip, knee, elbow, ankle, or finger)			If yes, please specify joint and date of surgery:
Are you taking or have you taken the medications Alendronate (Fosamax) or Risedronate (Actonel) for Osteoporosis or Paget's Disease?			If yes, please specify date treatment began:
Since 2001, were you treated or are you currently scheduled to begin treatment with I.V. bisphosphonate (Aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's Disease, Multiple Myeloma, or Metastatic Cancer?	е		If yes, please specify date treatment began:
Do you use controlled substances? (drugs)			If yes, please specify substance:
Do you use tobacco? (smoking, snuff, chew, vape)			If yes, are you interested in stopping?
Do you drink alcoholic beverages?			If yes, how much in the last 24 hrs & average in a week?
BELOV	N FOR	WON	MEN ONLY
Are you currently or could you possibly be pregnant?			If yes, how many weeks?
Are you currently nursing?			
Are you taking birth control or hormone replacement?			
Responsible Party Signature:			Date:



ALLERGIES

*Please CHECK if you are allergic to or have had any reaction to the substances below: * ☐ Local Anesthetics Sulfa Drugs Iodine ☐ Other (please list below) Aspirin □ Codeine or other ☐ Hay Fever/ ☐ Penicillin or Other Antibiotics Narcotics Seasonal Animals ☐ Barbiturates, Sedatives, Metals Food or Sleeping Pills ☐ Latex (Rubber) CONGENITAL HEART DISEASE (CHD) *Please CHECK if you have had any of the following heart conditions or treatments: * ☐ Artificial (prosthetic) heart valve ☐ Congenital heart disease (CHD) ☐ Repaired CHD completely in the last 6 months □ Previous Infective Endocarditis ☐ Unrepaired, cyanotic CHD ☐ Damaged valves in transplanted heart ☐ Repaired CHD with residual defects OTHER DISEASES AND CONDITIONS *Please CHECK if you have had or currently have any of the following conditions: * ☐ Cardiovascular Disease ☐ AIDS or HIV ☐ Thyroid Problems ☐ Angina Arthritis ☐ Stroke ☐ Arteriosclerosis ☐ Autoimmune Disease (date:) ☐ Glaucoma ☐ Congestive Heart Failure ☐ Rheumatoid Arthritis ☐ Hepatitis, Jaundice, or Liver Disease □ Damaged Heart Valves ☐ Systematic Lupus ☐ Heart Attack ☐ Asthma Epilepsy ☐ Fainting Spells or Seizures (date:) □ Bronchitis Neurological Disorders (specify below) ☐ Heart Murmur Emphysema ☐ Low Blood Pressure Sinus Trouble ☐ High Blood Pressure Tuberculosis ☐ Sleep Disorder ☐ Other Heart Defects ☐ Mental Health Disorders (specify below) ☐ Cancer/Chemotherapy/ ☐ Mitral Valve Prolapse **Radiation Treatment** ☐ Recurrent Infections Pacemaker (date: ☐ Chest Pain upon exertion **Kidney Problems** ☐ Rheumatic Fever ☐ Chronic Pain ☐ Night Sweats Osteoporosis ☐ Rheumatic Heart Disease ☐ Diabetes Type 1 ☐ Abnormal Bleeding ☐ Diabetes Type 2 ☐ Persistent Swollen Neck Glands ☐ Anemia ☐ Eating Disorder ☐ Severe Headaches/Migraines Severe or Rapid Weight Loss □ Blood Transfusion ☐ Malnutrition (date: _____) Sexually Transmitted Disease ☐ Gastrointestinal Disease ☐ Hemophilia ☐ Excessive Urination ☐ G.E. Reflux/ Persistent Heartburn **PREMEDICATION** Has a physician or dentist recommended that you take antibiotics prior to every dental visit/procedure? □ No □ Yes If yes, please provide name of physician/dentist and number:_____ **OTHER NOTABLE CONCERNS OR CONDITIONS** - Please provide/explain any other conditions or concerns:

Responsible Party Signature: Date:



HIPPA/ PATIENT PRIVACY ACT

The <u>Health Insurance Portability and Accountability Act</u> requires that our office complies 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 HIPPA's requirements, we are offering to provide you a copy of our <u>Notice of Privacy Practices</u>. Please let one of our administrative staff know if you would like to view and/or take home the copy of privacy practices.

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

It may be necessary for us to disclose your information in connection with your treatment; for example, a referral or consultation with another dentist or healthcare professional or providing material and case details to a laboratory.

If you have any other person(s) that you would like to grant permission for Bohn Dental staff to be able to discuss your treatment, appointments, finances, insurance, and/or diagnosis or concerns with, they need to be listed below:

товинон, аррони		
	Name:	Relation:
	Name:	Relation:
	Name:	Relation:
LATE CANCELLAT	ION OR MISSED APPOINTMENT POLICY	
every patient to be comfortable and ur appointment time, At Bohn Dental, we schedule, as well as	seen precisely at their appointment time and the nrushed. As a single-doctor practice, we do not our entire staff is waiting to greet you and prove do everything possible to make sure that we consoler. Our team will provide reminders of your	r us to prioritize our schedule, at Bohn Dental, we strive for o provide enough time for treatment for our patients to feel double-book appointments; if you have a reserved vide you a service. an see you on the days and times that work well for your appointments 3 weeks ahead of your appointment, 1 weeks have not received a confirmation from you at your 3-day
	rovide us with your preferred method of comm	
	would like TEXT message reminders ONLY	I would like phone CALL reminders ONLY
If you are unable to	keep your reserved appointment time, please	provide 48-hour notice for rescheduling or cancelling.
a \$40 fee will be a	oplied to your account and payment will be req	ur appointment or if you fail to appear for your appointment uired to be remitted before scheduling another appointment vaiver of this fee to be utilized at their discretion.
If your personal sch	nedule and/or career make it difficult to reserve	e days/times for appointments as you are more "on-call",

please ask to be placed on our same-day opportunity list; we will contact you if we have an available appointment open within

I would like to be offered same-day opportunities for my appointments

Responsible Party Signature: _____ Date: _____

24 hours and you can elect to accept or not, the appointment will be reserved on a first-response basis.