bohn dental

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New Patient Information

Full Legal Name: _____ Date of Birth: _____

Preferred Name and/or Nickname: _____ Social Security #: _____-_____-_____

Cell Phone Number: _____ Street Address: _____

Home Phone Number: _____ Apartment #: _____

Email Address: _____ City, State, Zip: _____, MI, _____

Job Title: _____ Employer:_____

How did you hear about our office? (please check below)

☐ I was referred by _____, a ☐friend ☐family member ☐co-worker
(Full Name of person(s) who referred you)

☐ Google ☐ Postcard ☐ Bohn Dental Website ☐ Office Location

☐ Facebook/Instagram ☐ Magazine ☐ Insurance Company ☐ In-Person Event

Dental Insurance Information

Insurance Company: _____ Group/Plan #: _____

Do you have a Secondary Insurance Policy? (*please circle*) YES NO

***** Please provide the following information ONLY IF the subscriber/policy holder is different than person above *****

Subscriber/Policy Holder Name: _____ Date of Birth: _____

Subscriber's Employer: _____ Social Security #:_____-_____-_____

Financial Responsibility and Assignment of Benefits:

Our staff will do our best to provide accurate estimates of insurance remittance. However, all co-pays are estimated. It is important to understand your obligation is to pay for treatment in full, regardless of the amount that may or may not be reimbursed by your insurance company. Therefore, your estimated co-pay will be collected at time of service but an additional amount due could come as a statement to you after your insurance remits your benefits to our office.

We will bill your insurance company as a courtesy with your consent (as signed below). If your insurance company has not remitted payment within 90 days, you will be responsible for the account balance and must seek reimbursement from your insurance company.

If you are unable to fulfill your financial responsibility for a service, we do reserve the right to not perform the service.

I have read and accept the terms and conditions of my financial responsibility and this assignment of benefits agreement. I authorize my insurance company to pay my dental benefits directly to Bohn Dental PLLC and will inform them of any changes to my insurance policy. I understand that verifying my dental insurance is active at the time of every procedure/treatment is my personal responsibility.

Responsible Party Signature: _____ Date: _____

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TUBERCULOSIS CHECK

Please check if you have had any of the following diseases or health concerns:

- ☐ Active Tuberculosis
- ☐ Been Exposed to anyone with Tuberculosis
- ☐ Persistent cough lasting more than 3 weeks
- ☐ Cough that produces blood

GENERAL HEALTH INFORMATION

Preferred Pharmacy: _____ Phone: _____ Street/City: _____

Medical Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____ Location: _____

Please check "YES" or "NO" to the following health questions 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?			**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?
BELOW FOR WOMEN 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: _____

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ALLERGIES

**Please CHECK if you are allergic to or have had any reaction to the substances below: **

- ☐ Local Anesthetics
- ☐ Aspirin
- ☐ Penicillin or Other Antibiotics
- ☐ Barbiturates, Sedatives, or Sleeping Pills
- ☐ Sulfa Drugs
- ☐ Codeine or other Narcotics
- ☐ Metals
- ☐ Latex (Rubber)
- ☐ Iodine
- ☐ Hay Fever/ Seasonal
- ☐ Animals
- ☐ Food
- ☐ Other (please list below)
- ☐ _____
- ☐ _____

CONGENITAL HEART DISEASE (CHD)

**Please CHECK if you have had any of the following heart conditions or treatments: **

- ☐ Artificial (prosthetic) heart valve
- ☐ Previous Infective Endocarditis
- ☐ Damaged valves in transplanted heart
- ☐ Congenital heart disease (CHD)
- ☐ Unrepaired, cyanotic CHD
- ☐ Repaired CHD with residual defects
- ☐ Repaired CHD completely in the last 6 months

OTHER DISEASES AND CONDITIONS

**Please CHECK if you have had or currently have any of the following conditions: **

- ☐ Cardiovascular Disease
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Congestive Heart Failure
- ☐ Damaged Heart Valves
- ☐ Heart Attack (date:_____)
- ☐ Heart Murmur
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Other Heart Defects
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker (date:_____)
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Blood Transfusion (date: _____)
- ☐ Hemophilia
- ☐ AIDS or HIV
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Rheumatoid Arthritis
- ☐ Systematic Lupus
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinus Trouble
- ☐ Tuberculosis
- ☐ Cancer/Chemotherapy/ Radiation Treatment (date:_____)
- ☐ Chest Pain upon exertion
- ☐ Chronic Pain
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Eating Disorder
- ☐ Malnutrition
- ☐ Gastrointestinal Disease
- ☐ G.E. Reflux/ Persistent Heartburn
- ☐ Thyroid Problems
- ☐ Stroke (date:_____)
- ☐ Glaucoma
- ☐ Hepatitis, Jaundice, or Liver Disease
- ☐ Epilepsy
- ☐ Fainting Spells or Seizures
- ☐ Neurological Disorders (specify below) _____
- ☐ Sleep Disorder
- ☐ Mental Health Disorders (specify below) _____
- ☐ Recurrent Infections
- ☐ Kidney Problems
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Persistent Swollen Neck Glands
- ☐ Severe Headaches/Migraines
- ☐ Severe or Rapid Weight Loss
- ☐ Sexually Transmitted Disease
- ☐ Excessive Urination

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: _____

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HIPPA/ PATIENT PRIVACY ACT

The Health Insurance Portability and Accountability Act 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 Notice of Privacy Practices. 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:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

LATE CANCELLATION OR MISSED APPOINTMENT POLICY

One of the main benefits to a small family practice is the ability for us to prioritize our schedule, at Bohn Dental, we strive for every patient to be seen precisely at their appointment time and to provide enough time for treatment for our patients to feel comfortable and unrushed. As a single-doctor practice, we do not double-book appointments; if you have a reserved appointment time, our entire staff is waiting to greet you and provide you a service.

At Bohn Dental, we do everything possible to make sure that we can see you on the days and times that work well for your schedule, as well as ours. Our team will provide reminders of your appointments 3 weeks ahead of your appointment, 1 week ahead, and 3 days ahead; we will also call you the day before if we have not received a confirmation from you at your 3-day reminder. Please provide us with your preferred method of communication:

☐ I 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**.

If you provide less than 48-hour notice to cancel or reschedule your appointment or if you fail to appear for your appointment, **a $40 fee will be applied to your account** and payment will be required to be remitted before scheduling another appointment with our practice. Every patient will be provided with a one-time waiver of this fee to be utilized at their discretion.

If your personal schedule and/or career make it difficult to reserve 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 24 hours and you can elect to accept or not, the appointment will be reserved on a first-response basis.

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

Responsible Party Signature: _____ Date: _____