Karl E. Bohman, D.D.S., P.C. **Exceptional Dentistry…One Smile at a Time**

Patient Information and Health Questionnaire

Name: _____ Date of Birth _____ Sex: Male Female

Name you prefer our team to address you by: _____ Status: Single Married Child < 18 Other: _____

Whom may we thank for referring you to our office? _____

Address: _____ Home Phone: _____
Number/Street City/State Zip

Business Phone: _____ Cell Phone: _____ E-mail address _____

Please circle preferred method of contact: Home phone Business Phone Cell phone E-mail

Employer: _____

Spouse or Responsible Party to Child/Patient Name: _____

Business Phone: _____ Employer: _____E-mail address _____

Person to contact in case of emergency: _____ Phone: _____

Medical History

We are interested in your total health. Please pay close attention to our health questions so that we may be of better service to you.

Please circle any of the following, which apply to you

Heart Disease/Attack	Headaches (persistent)	A.I.D.S. (HIV positive)	Stroke
Angina Pectoris	Emphysema	Hepatitis A	Muscular Dystrophy
High Blood Pressure	Persistent Cough	Hepatitis B	Multiple Sclerosis
Low Blood Pressure	Tuberculosis	Liver Disease	Bleeding Disorders
Heart Murmur	Asthma	Chemical Dependency	Glaucoma
Rheumatic Fever	Hay Fever	Hemophilia	Speech Impediment
Congenital Heart Defects	Sinus Trouble (Infections)	Venereal Disease	Anemia
Scarlet Fever	Allergies or Hives	Cold Sores (Fever Blisters)	Arthritis (Rheumatism)
Artificial Heart Valve	Diabetes	Epilepsy or Seizures	Hearing Problems
Pacemaker	Thyroid Problems	Fainting or Dizzy Spells	Pregnant-Month ____
Heart Surgery	Cancer or Tumors	Nervous Disorders	Breast feeding
Artificial Joints (Hip, Knee, etc.)	Radiation Treatment	Psychiatric Treatment	Birth Control
Blood Transfusion (s)	Chemotherapy	Lupus Erythematosis	

Are you aware of being allergic to or have you ever reacted adversely to any of the following?

Penicillin or other Antibiotics	Codeine or other Narcotics	Barbiturates or Sedatives Latex
Aspirin, Ibuprofen, Aleve	Local Anesthetics (Novocaine/Xylocaine)	Nitrous Oxide

Other: _____

Are you currently under a physician's care: Yes No
If yes: Condition (s) being treated: _____

Physician's Name: _____ Phone: _____
Are you currently taking any medication, drugs, or pills Yes No
If yes, please list medications and dosage? _____
_____

Have you been prescribed any medication you are not currently taking? Yes No
If yes, Medication and Dosage: _____

Do you have any disease, condition, or problem not listed? Yes No
If yes, please explain, _____

Dental Insurance Information:

Insured's Name _____Insured's ID/SS # _____ Birth date _____

Insurance Company _____ Group # _____Relationship to Patient: _____

Insurance Company Address _____ Phone: _____
Number/Street City/State Zip

Secondary Insured's Name _____ Insured's ID/SS# _____ Birth date _____

Insurance Company _____ Group # _____Relationship to Patient: _____

Insurance Company Address _____ Phone: _____
Number/Street City/State Zip

Consent:

1. I understand the above information is necessary to provide patients with dental care in a safe and efficient manner.
2. I have answered all questions truthfully and to the best of my knowledge. I agree to notify the doctor of any changes at subsequent visits.
3. I authorize the doctor to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's needs. I consent to be photographed before, during, and after treatment. These photographs shall remain property of Dr. Bohman and may be published in dental journals, office manuals and/or shown for education purposes. I understand that my first name may be used with these photos for identification purposes.
4. I will be given the opportunity to discuss my treatment plan with the doctor prior to beginning any treatment.
5. I give my consent for the dental treatment, medication, or therapy indicated on my treatment plan and any other treatment deemed advisable as a corollary to this treatment plan.
6. I understand that all information on this patient information form will be held in strict confidence and in accordance with all HIPPA rules and regulations.
7. I understand this practice has a 48-hour appointment cancellation policy. In addition the practice needs to be able to effectively contact each patient.
   I understand that this practice must receive my appointment confirmation **one working day** in advance or my appointment time will be offered to another patient. I understand I will receive a courtesy message to reschedule my appointment.
   If a **second** late notice cancellation occurs I will receive a letter to politely remind me of the 48 hour cancellation policy.
   The **third** late notice cancellation **and beyond** my account will be charged a $150.00 rescheduling fee in addition to payment in full of the scheduled treatment should I choose to remain a patient.

Financial Responsibility:

In accordance with the Federal Truth-in-Lending Act the following policies apply in our office:

1. Payment is due at the time treatment is rendered or by previous financial arrangements.
2. In the event my insurance company does not cover the entire balance of my account within 30 days from treatment date, I agree to pay the balance in full within 60 days of treatment date or by previous financial arrangements
3. Payments extended beyond thirty (30) days from first billing will accrue interest at the rate of 1 ½ % per month on the unpaid balance (18% annual rate).
4. There is a forty dollar ($40) charge on all returned checks.
5. Personal credit may be checked.
6. In the event of default, I agree to pay legal interest on the indebtedness, any collection costs, and related attorney's fees.

Patient/Responsible Party Signature: _____
Date: _____