Dr. Mchael Boehm Family Dentistry

Patient Information

Patient Name: ____ Date: __________ ☐ Male ☐ Female
Last First MI (Preferred Name)

Social Security #: ______________________ Birth Date: ______________________

Phones H: ____________ C: ____________ Email: ______________________________

Do You Prefer to be contacted by Phone Call ☐ Text ☐ Email ☐ **Note**: We do require a response to all confirmation calls

Address: ____
Street Apartment #

____
City State Zip Code

Name of **Medical Doctor**: ______________________ Phone # ______________________

Name of **Previous Dentist**: #: ______________________ Date of last Dental visit: ______________________

Who may we thank for referring you? ______________________________________

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

His/he Name: ______________________ Relationship ______________________

Phone #s: H) ______________ C): ______________ W): ______________

If patient is a Minor- Responsible Party Information

Name: ______________________ Relationship: ☐ Parent ☐ Other ______________

Social Security #: ______________________ Birth Date: ______________________

Phone H): __________ C): __________ W): __________ Ext: ______ Best time to call: ______________

Address: ____
Street Apartment #

____
City State Zip Code

Employer Name: ______________________________________ Phone: ______________

Consent for Services

I understand the information that I have given today on this and the following pages is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

______________________________________ ______________________
Signature of Patient, Parent or Guardian, or Responsible Party Date

Dr. Mchael Boehm Family Dentistry

Dental Health History

What brought you in to see us today (specifically)?____

Y N Do you gag easily?
Y N Does food catch between your teeth?
Y N Do you have difficulty in chewing your food?
Y N Do your gums bleed when you floss?
Y N Are your teeth sensitive to: Hot Cold Other
Y N Are you aware of an uncomfortable bite?
Y N Are you dissatisfied with the appearance of your teeth?
Y N Do you clench or grind your jaws frequently?
Y N Do you have pain in the face, cheeks, jaws, joints, throat, or temples, ears

How often do you brush? _________________________
How often do you floss? _________________________
Y N Does your jaw make noise so that it bothers you or others?
Y N Do you have earaches or pain in front of the ears?
Y N Do you take medications or pills for pain or discomfort?
Y N Do you have any jaw symptoms or headaches upon waking in the morning?
Y N Do you prefer to save your teeth?
Y N Are you interested in whitening/bleaching your teeth?
Y N Have you ever needed an antibiotic prior to dental treatment?

Medical Health History

Do you have, or have you had, any of the following?

Y N Abnormal Bleeding
Y N ADHD(Attention Deficit/Hyperactivity Disorder)
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis / Rheumatism
Y N Artificial Joint(s) such as: total joint, pins, implants, or_________
Y N Asthma
Y N Back / Neck Pain
Y N Cancer
Y N Depression
Y N Diabetes, type________
Y N Epilepsy
Y N Fainting/Dizziness

Y N Glaucoma
Y N Head Injuries
Y N Psychiatric Treatment
Y N Heart Problems
Y N Hepatitis (A, B, C, other___)
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV Positive / AIDs
Y N Kidney Disease
Y N Liver Disease
Y N Low Blood Pressure
Y N Mental Disorders
Y N TB – Tuberculosis
Y N MS – Multiple Sclerosis

Y N Nervous Disorders
Y N Pacemaker
Y N Ulcers
Y N Radiation or Chemo Therapy
Y N Thyroid Problems
Y N Rheumatic / Scarlet Fever
Y N Shortness of Breath
Y N Sinus Problems
Y N Sexually Transmitted Disease
Y N Stomach Problems
Y N Stroke(s)
Y N Tumors

Y N Are you/have you taken medication for osteoporosis or osteoarthritis? (Fosamax, Actonel, Boniva, or_________)
Y N Do you smoke or use smokeless tobacco? If yes, which and how much daily?__________________________

Please circle if you have or had any of the following conditions:

- A cardiac transplant that develops a heart valve condition
- Artificial heart valves
- A history of infective endocarditis
- The following congenital (present from birth) heart conditions:
  - Unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
  - A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure.
  - Any repaired congenital heart defect with residual defect at the site or adjacent to the site of the prosthetic patch or a prosthetic device

Any other disease or medical condition?____

Please read carefully and answer if you have now or ever have had, any of the following:

Are you ALLERGIC to or have REACTED ADVERSLY to any of the following?

Y N Local anesthetics ("Novocaine")
Y N Penicillin, other antibiotics ________________
Y N Barbiturates, sedatives
Y N Aspirin, Acetaminophen, or Ibuprofen
Y N Codeine, Hydrocodone, other narcotics
Y N Latex or rubber
Other _________________________

Current Medications (and why taking):

____
____
____

During the past 12 months, have you taken any of the following?

Y N Antibiotics or sulfa drugs
Y N Anticoagulants (e.g., Coumadin)
Y N Digitalis or drugs for heart trouble
Y N Cortisone (steroids)
Y N Aspirin
Y N Nitroglycerin
Y N Natural remedies
Y N Nonprescription drug/supplements
Prescription Pain Medication
When?______________________
How Many?___________________

WOMEN

Y N Hormone Replacement Therapy?
Med:____________________
Y N Are you taking contraceptives**?**
Y N Are you pregnant?
If so, expected delivery date: ______________
Y N Are you nursing?

Dr Michael Boehm Family Dentistry

Cancellation Policy

At Dr Michael Boehm Family Dentistry, we have developed a cancelation policy that is fair to both our patients and our practice. We respect your time by both getting you seated and released as scheduled.

Canceling less than 48 hour notice, failing to show for appointments, or arriving late is disruptive to our schedule and other patients. We request 48 hour notice for cancellations or rescheduling of appointments. In the instance of a late cancellation (less than 24 hour notice) or a failed appointment there may be a $50 charge per hour of scheduled appointment time.

Thank you so much for putting your faith and trust in Dr. Michael Boehm Family Dentistry.

Financial Agreement

It is our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable.

Our office does not carry patient balances. We are pleased to offer you these options for payment:

Payment in full with check or cash
Debit cards
VISA ,MasterCard ,Discover, American Express
CareCredit – A form of little or no-interest financing

As a courtesy, we will process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier. We are in no way responsible for your dental bill if your insurance company does not pay. We will do our best to give you an *estimated* co-payment amount based on the insurance information we have available to us.
You are ultimately responsible for your entire dental bill. If your insurance does not pay their anticipated amount, you will receive a billing statement from us that is due upon receipt.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. . . *our goal is to ensure that you have an outstanding experience.*

Your commitments to us:

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have.
I understand that estimates for future treatment will be honored for 90 days.
I understand that if for any reason my account remains unpaid for over 90 day it may be referred to collections. Should this happen, I am responsible for any and all collection and attorney fees.

________________________________ ________________________
Signature (responsible party) Date

Dr Michael Boehm Family Dentistry
Insurance Information

Primary

Name of Insured:

____

Last First MI

Is insured a patient? ☐ Yes ☐ No

Insured's relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

Insured's Birth Date: _______________ ID #: __________________

Group #: ______________________

Insured's Address:

____

Street Apartment #

____

City ***State*** ***Zip Code***

Insured's **Employer** Name___________________________________

Insurance Company Name:__________________________________

Ins. Co.____ Phone:______________

Secondary

Name of Insured:

____

Last First MI

Is insured a patient? ☐ Yes ☐ No

Insured's relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

Insured's Birth Date: _______________ ID #: __________________

Group #: ______________________

Insured's Address: ____

Street Apartment

____City

State Zip Code

Insured's **Employer** Name:_________________________________

Insurance Company Name:__________________________________

Ins. Co. Phone:____

Vital Information about your Dental Insurance

Our office is happy to help you file your insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans vary from company to company, with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance will only pay what it allows for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built into most plans and state law strictly regulates their required payment. Your Employee Benefits Director can usually help you become familiar with your plan and its restrictions, and our office will assist you in maximizing your benefits.

Our responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you within 24 hours of treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time within a 60 day period.

Your responsibilities:

1. To pay fees not covered by your plan at the time of treatment.
2. To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims. In particular, inform us of any changes.
3. To understand that your plan is a contract between you and your employer and the insurance company. Our office will do all we can to facilitate claim payment, but we do not have the power to make your plan pay for services.
4. To pay any account balance not paid by insurance after two billing attempts.

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. Please sign this form (below) and provide insurance information on the back of this form. We will keep one copy in your file and will give you one copy for your records.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental / medical histories and other information about my dental treatment to third party payers.

________________________________ ____________________

Patient or Insured Date