Patient Name_____

Home Address_____

City _____

State _____ Zip Code _____

Social Security Number_____

Cell Phone _____

Birthday_____

Email Address: _____

Insurance information: ◯ Same ◯ Changed

Name of Policy Holder: _____

Date of birth of Policy Holder:_____

Relationship to patient _____

Social Security Number policy holder:

_____

Insurance Company Name: _____

Group #_____ Member ID_____

Address on back of card

_____

_____

Do you have secondary insurance coverage?

◯ Yes ◯ No

Responsible Party/Guarantor:

Is the patient the guarantor? _____

Guarantor Name _____

Relationship to patient _____

Phone number and address of Guarantor (If different) _____ _____

_____

_____

X-Ray and Insurance Coverage: We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

_____ (signature)

Financial Policy: The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

- All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance.
- This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.
- Payment for services is due at the time of treatment. Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

_____ (signature)

Cancellation Policy: We request a 48-hour notice if you need to cancel your appointment. You can call, email, or text us. A cancellation fee of 75 dollars per hour will be charged for every appointment canceled within 48 hours. _____ (Initial)

Photo Consent: I Authorize Dr. Tara Boshnack DDS to take photographs and/or videos of my face, jaws, and teeth, before during and after treatment. I consent to allow the photographs to be used for the following: Dental Records Dental Research Dental education including lectures, seminars, demonstrations, professional publications such as journals or books Marketing materials. Including websites and printed materials, patient education. I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise for the use of these photographs.

_____ (signature)

HIPPA: Acknowledgement of receipt of Notice of Privacy Practices (Hippa). I _____ (Print name), have received a copy of this office's Notice of Privacy Practices.

_____ (signature) _____Date

Dental History:

Reason for Visit: _____

Do you Floss? ◯ Yes ◯ No
Do you brush your teeth? ◯ Yes ◯ No
Do you grind your teeth? ◯ Yes ◯ No
Do you have broken/loose fillings/teeth ◯ Yes ◯ No
Pain on ear/side of face ◯ Yes ◯ No
Sores/Blisters in mouth ◯ Yes ◯ No
Clicking popping jaw ◯ Yes ◯ No
Interested in whitening your smile? ◯ Yes ◯ No
Are you happy with your smile? ◯ Yes ◯ No

List any other dental concerns: _____

_____

What did you like most about your previous dental office? _____

_____

What did you like least about your previous dental office? _____

_____

Medical history

Do you smoke? ◯ Yes ◯ No
Do you drink alcohol? ◯ Yes ◯ No
Do you use recreational drugs? ◯ Yes ◯ No
If yes, which drug _____
Are you pregnant? ◯ Yes ◯ No
Are you nursing? ◯ Yes ◯ No
Are you under care of a physician? ◯ Yes ◯ No

Physician Name: _____

Physician Contact number: _____

List any serious illnesses/surgeries/ hospitalizations_____

_____

Describe the patient's current physical health: ◯ Good ◯Fair ◯ Poor

Are you taking any medicine? ◯ Yes ◯ No

List any medicines you are taking (even vitamins)

_____

_____

_____

Have you ever taken bisphosphonates or fosomax?
◯ Yes ◯ No

List any Allergies _____

_____

Allergy: Aspirin ◯ Yes ◯ No
Allergy: Latex ◯ Yes ◯ No
Allergy: Local Anesthesia ◯ Yes ◯ No
Allergy Penicillin: ◯ Yes ◯ No
Allergy: Sulfa ◯ Yes ◯ No
Abnormal Blood pressure ◯ Yes ◯ No
AIDS/HIV ◯ Yes ◯ No
Artificial heart valves ◯ Yes ◯ No
Autoimmune conditions ◯ Yes ◯ No
Congenital heart lesions ◯ Yes ◯ No
Heart problems ◯ Yes ◯ No
Pacemaker ◯ Yes ◯ No
Arthritis/Rheumatism/Gout ◯ Yes ◯ No
Artificial Joints/Bones ◯ Yes ◯ No
Asthma ◯ Yes ◯ No
Cancer ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No
Emphysema ◯ Yes ◯ No
Glaucoma ◯ Yes ◯ No
Radiation treatment ◯ Yes ◯ No
Shortness of breath ◯ Yes ◯ No
Sinus trouble ◯ Yes ◯ No
Stroke ◯ Yes ◯ No
Thyroid problems ◯ Yes ◯ No
Tuberculosis ◯ Yes ◯ No
Tumor/Growth on head/neck ◯ Yes ◯ No
Ulcer ◯ Yes ◯ No
Epilepsy ◯ Yes ◯ No
Fainting/Dizzy ◯ Yes ◯ No
Headaches ◯ Yes ◯ No
hepatitis ◯ Yes ◯ No
Herpes ◯ Yes ◯ No
HPV: ◯ Yes ◯ No
Kidney disease/Dialysis ◯ Yes ◯ No
Liver disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No

List any other medical conditions_____

_____

I certify that this information is accurate to the best of my knowledge.

_____ (Signature) _____ (Date)