OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE

NAME | NAME I LIKE TO BE CALLED

MAILING ADDRESS

CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE — EXT.

SOCIAL SECURITY #:

BIRTH DATE | ☐ MALE ☐ FEMALE

MARITAL STATUS

SPOUSE'S NAME

PARENT OR GUARDIAN RESPONSIBLE FOR CHILD'S ACCOUNT

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE

CHILD'S NAME | NICK NAME

MAILING ADDRESS

CITY | STATE | ZIP CODE

HOME PHONE

BIRTH DATE | AGE | ☐ MALE ☐ FEMALE

SCHOOL | GRADE

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature of Parent or Guardian | Date

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

EMPLOYEE

DATE OF BIRTH

GROUP NO.

EMPLOYER PROVIDING INSURANCE

DATE EMPLOYED

EMP. SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

EMPLOYEE

DATE OF BIRTH

GROUP NO.

EMPLOYER PROVIDING INSURANCE

DATE EMPLOYED

EMP. SOCIAL SECURITY NO.

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signed (Patient or Parent if Minor) | Date

I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

Signed (Insured Person) | Date

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

DRIVERS LICENSE NO. | RELATIONSHIP TO PATIENT

ACCEPTABLE FORMS OF PAYMENT:

☐ CASH ☐ PERSONAL CHECK ☐ MASTERCARD/VISA/DISCOVER

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

YOU:

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS TELEPHONE | EXT.

YOUR SPOUSE:

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS TELEPHONE | EXT.

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

THEIR NAME:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

DO YOU HAVE ANY SPECIAL INTERESTS, SPORTS OR HOBBIES?

PERSON TO CONTACT FOR EMERGENCY

NAME | PHONE

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

NAME | PHONE

ADDRESS

CITY | STATE | ZIP

Date _____

DENTAL HISTORY

Please circle the appropriate answer:

1. Regular dental care in the past ..... **Yes** / No
2. Happy with appearance of teeth? ..... **Yes** / No
3. Chew on both sides of mouth? ..... **Yes** / No
4. Teeth unusually sensitive to:
   Cold ☐ Sweets ☐ Hot ☐ Biting Pressure ☐
5. Frequent Headaches? ..... Yes / **No**
6. Bothered by injections? ..... Yes / **No**
7. Had "laughing gas" during treatment? ..... **Yes** / **No**
8. Had complete mouth X-ray? ..... **Yes** / No
   If "Yes," please give date _____
9. Pleased with health of teeth? ..... **Yes** / No
10. Gums bleed when brushing? ..... Yes / **No**
11. Unusual swelling in mouth? ..... Yes / **No**
12. Unusual/frequent pain in:
    Teeth ☐ Jaw Joints ☐ Jaws ☐ Ears ☐
13. Frightened by treatment? ..... Yes / **No**
14. Have you worn braces? ..... **Yes** / **No**
15. Have you been told you have periodontal disease? ..... Yes / **No**

CURRENTLY:

1. Do you have pain or discomfort at this time? ..... Yes / **No**
2. Have you been a patient in the hospital during the past two years? ..... Yes / **No**
3. Have you been under the care of a medical doctor during the past two years? If "Yes," reason: _____ ..... Yes / **No**
   Physician's Name _____ Address _____ Telephone _____
4. Have you taken any medication or drugs during the past two years? ..... Yes / **No**
5. Are you now taking any medication, drugs or pills? If yes, please list: _____ ..... Yes / **No**
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... Yes / **No**
   If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	Yes / No	Stroke	Yes / No	Hepatitis A (infectious)	Yes / No
Heart Disease or Attack	Yes / No	Artificial Joints (Hip, Knee, etc.)	Yes / No	Hepatitis B (serum)	Yes / No
Angina Pectoris	Yes / No	Kidney Trouble	Yes / No	Venereal Disease	Yes / No
Congenital Heart Disease	Yes / No	Ulcers	Yes / No	A.I.D.S.	Yes / No
Heart Murmur	Yes / No	Diabetes	Yes / No	H.I.V. Positive	Yes / No
High Blood Pressure	Yes / No	Thyroid Problems	Yes / No	Cold Sores/Fever Blisters	Yes / No
Arteriosclerosis	Yes / No	Glaucoma	Yes / No	Blood Transfusion	Yes / No
Mitral Valve Prolapse	Yes / No	Cosmetic Surgery	Yes / No	Hemophilia	Yes / No
Artificial Heart Valve	Yes / No	Emphysema	Yes / No	Anemia	Yes / No
Heart Pacemaker	Yes / No	Chronic Cough	Yes / No	Sickle Cell Disease	Yes / No
Heart Surgery	Yes / No	Tuberculosis	Yes / No	Bruise Easily	Yes / No
Rheumatic Fever	Yes / No	Asthma	Yes / No	Liver Disease	Yes / No
Arthritis	Yes / No	Hay Fever	Yes / No	Yellow Jaundice	Yes / No
Rheumatism	Yes / No	Allergies or Hives	Yes / No	Epilepsy or Seizures	Yes / No
Pain in Jaw Joints	Yes / No	Sinus Trouble	Yes / No	Fainting or Dizzy Spells	Yes / No
Cortisone Medicine	Yes / No	Radiation Therapy	Yes / No	Nervousness	Yes / No
Drug Addiction	Yes / No	Chemotherapy	Yes / No	Psychiatric Treatment	Yes / No

7a. Have you been told by your Physician to be pre-medicated before dental treatment? ..... Yes / No
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... Yes / No
9. Do your ankles swell during the day? ..... Yes / No
10. Do you use more than two pillows to sleep? Yes / No
11. Have you lost or gained more than 10 pounds in the past year? ..... Yes / No
12. Do you ever wake up from sleep and feel short of breath? ..... Yes / No
13 Are you on a special diet? ..... Yes / No
14. Has your medical doctor ever said you have a cancer or tumor? ..... Yes / No
15. Do you have or have you had any disease, condition, or problems not listed? If yes, please list: _____ ..... Yes / No

For Women Only

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Consent

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 45 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Legal Gaurdian _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT.

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization

- Treatment
- Payment
- Health care operations
- When release if required by law, including in judicial settings, to health oversight regulatory agencies and law enforcement.
- In emergency situation or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
- To organ, tissue and other donation preferences (or a positive indication)
- To contact you about appointment reminders, treatment alternatives and other health related benefits and services.
- To the sponsor of your health plan.
- All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning you PHI:

- Restrictions: To request restricted access to all or part of your PHI. To do this, you must contact our privacy officer or contact. We are not required to grant your request.
- Confidential communications: To receive correspondence of confidential information by alternate means or location. To do this, you must contact our privacy officer or contact.
- Access: To inspect or receive copies of your protected health information. To do this you must contact our privacy officer or contact.
- Amendments: To request changes made to your PHI. To do this, you must Contact our privacy officer or contact. We are not required to grant your request.
- Accounting: To receive an accounting of the disclosures by us of your PHI in The six years prior to your request. To do this, you must contact our privacy officer or contact.
- This notice: To get updates or reissue of this notice at your request.
- Complaints: To complain to us or the U. S. Dept of Health and Human Services if you feel your privacy rights have been violated. To register a complaint with us, please contact our privacy officer. The law forbids us from taking retaliatory action against you if you complain.

Our duties: We are required by law to maintain the privacy of you PHI. We must abide by the terms of this notice or any update OF THIS NOTICE.

Privacy contact: For more information about our privacy practices, please contact: Chris McKenzie, Privacy Officer
Effective Date: April 1, 2003

I acknowledge receipt of this notice:

Signature_____Date_____
Print Name of Patient_____

Signature of the patient's representative or guardian_____
Print your name_____Describe your authority_____

Donald H. Bohne, D.D.S., P.A.
4958 Lavista Road
Tucker, GA 30084
770-939-6600 Fax 770-939-1287

Dear Patient,

The overhead in all dental offices is very high and it continues to grow each year as we have inflation and price increases. It is the goal of our office to offer the best available dental service for a reasonable fee. As you know, if you are on a dental program that has preferred providers, our services are at a reduced fee. Therefore, it is imperative that we have at least a **48 hour notice of cancellation** of an appointment. The word "you" shall mean you or your dependent. If we do not receive adequate notice from you, your account will be charged for the services that were to be rendered during that missed appointment. This charge must be paid before your appointment can be rescheduled. Your insurance company will not pay for charges for missed appointments for you or your dependents.

You are given one free appointment to check work done from a previous procedure. After that, there is a charge for each visit regardless of the nature of the visit. Please be sure your bite is comfortable before you leave the office. Be forewarned, your insurance company will not pay for office visits of this nature.

I, the undersigned below, being a patient or responsible party, agree to pay all fees due to my failure to give a **48 hour notice of cancellation.**

_____ _____

Patient/Responsible Party Date

_____

Witness

We appreciate your understanding and cooperation in this policy and we look forward to serving you and your family.