MICHAEL M. Bohn DDS

PATIENT INFORMATION

Last Name _____ First _____ Middle _____
Nick Name _____ DOB ___/___/___ Social Security No. _____
School Attending _____ PT/FT Age_____ Single ☐ Married ☐ Divorced ☐ Widowed ☐

ACCOUNT INFORMATION

Primary:
Responsible Person
Last Name _____ First _____ Middle _____ M/F
Street _____ Employer Name _____
City _____ Street _____
State, Zip _____ City _____
Home Phone No. _____ Cell# _____ State, Zip _____
Single ☐ Married ☐ Divorced ☐ Widowed ☐ Work Phone No. _____ Ext. _____
Date of Birth _____/ _____/ _____ Social Security No. _____

INSURANCE COVERAGE

Insurance Carrier_____ Group No._____ Effective Date_____
Street _____ City _____ State _____ Zip _____

Secondary:
Responsible Person
Last Name _____ First _____ Middle _____ M/F
Street _____ Employer Name _____
City _____ Street _____
State, Zip _____ City _____
Home Phone No. _____ Cell: _____ State, Zip _____
Single ☐ Married ☐ Divorced ☐ Widowed ☐ Work Phone No. _____ Ext. _____
Date of Birth _____/ _____/ _____ Social Security No. _____

INSURANCE COVERAGE

Insurance Carrier_____ Group No._____ Effective Date_____
Street _____ City _____ State _____ Zip _____

GETTING TO KNOW YOU

1. Has any member of your family been a patient here before? Yes _____ No _____
   If yes, whom? _____ Relationship _____
2. Whom may we thank for referring you to our office? _____
3. Person to contact for emergency _____
   Address: _____ Telephone: _____
4. Closest relative not living with you _____
   Address: _____ Telephone: _____

Consent For Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a through diagnosis of (name of patient)_____'s dental needs.

2. Upon such diagnosis, I authorize doctor to preform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that 1-1/2% late charge (18%) may be added to my account. If required, I also understand a check of credit history may be made.

Patient's Signature_____ Date_____ Witness_____

Responsible Party's Signature_____ Relationship_____

Patient Name:_____ Medical Alerts:_____

Are you or have you taken: Boniva, Fosamax, Aredia, Actonel, Zometa. ..... YES NO

1. Are you having 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? ..... YES NO

   Physician's Name_____ Phone No. _____

   Address _____
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? ..... YES NO

   If yes, please list: _____
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	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Cosmetic Surgery	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	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
Stroke	YES	NO	Hepatitis A (infectious)	YES	NO	Developmentally Disabled	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 problem not listed? ..... YES NO

    If yes, please list: _____

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 above 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:

1. 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.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all 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 other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Michael M. Bohn, DDS
7730 N. Fresno St. Suite #102
Fresno, CA 93720

HIPAA Consent Form

The Health Insurance Portability and Accountability Act of 1996 provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. For this reason, our practice has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handle appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the rules of confidentiality.
4. The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties.
5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.
6. Your confidential information will not be used for purposes of advertising or marketing of products, goods or services. Such prohibition does not include treatment/product samples or goods of nominal value.
7. The practice agrees to provide the patient with access to their records in accordance with state law.
8. The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

If 18yrs. or older I consent to have my dental treatment and billing discussed with my parents.

_____
(Inital)

I,_____ do hereby agree to the terms set forth above and any subsequent
(Patient or Guardian)
changes in office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

_____
(Signature)

MICHAEL M. Bohn DDS

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Dr. Michael Bohn's office reserves the right to charge a fee of $50.00 for all missed appointments.

"No Shows" and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance.

And must be paid prior to your appointment. Multiple "No Shows" in any 12-month period may result in termination from the practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name **Date**

_____

Signature

7730 N. Fresno Street, #102 | Fresno, California 93720-2408 | phone (559) 432-4850 | fax (559) 432-4718 | http://www.bohndental.com

Patient Acknowledgement of Receipt of

Dental Materials Fact Sheet

I, _____ acknowledge I have Received a copy of

The Dental Materials Fact Sheet from Dr. Michael Bohn D.D.S.

_____ _____

Patient Signature Date