PATIENT REGISTRATION

ID: ________ Chart ID: ____________________

First Name: ________________________ Last Name: ________________________ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: ________________________

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ________________________ Last Name: ________________________ Middle Initial: ____

Address: ________________________ Address 2: ________________________

City, State, Zip: ________________________ Pager: ________________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Birth Date: ____________ Soc Sec: ____________ Drivers Lic: ____________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ________________________ Address 2: ________________________

City: ________________ State / Zip: ______ ________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ____________ Age: ______ Soc. Sec: ____________ Drivers Lic: ____________

E-mail: ________________________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ____________ Pref. Dentist: ____________

Employer ID: ____________ Pref. Pharmacy: ____________

Carrier ID: ____________ Pref. Hyg.: ____________

Section 3

Referred By: ____________

Previous Dentist: ____________

Emergency Contact: ____________

Emergency Contact #: ____________

Primary Insurance Information

Name of Insured: ________________________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ________________________ Ins. Company: ________________________

Address: ________________________ Address: ________________________

Address 2: ________________________ Address 2: ________________________

City,State,Zip: ________________________ City,State,Zip: ________________________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

Secondary Insurance Information

Name of Insured: ________________________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ________________________ Ins. Company: ________________________

Address: ________________________ Address: ________________________

Address 2: ________________________ Address 2: ________________________

City,State,Zip: ________________________ City,State,Zip: ________________________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

MEDICAL HISTORY

Name: ______________________________
Date of Birth: __________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________________

Are you on a special diet? ◯ Yes ◯ No ____________________

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ____________________

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ____________________

Comments: ____________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________________ DATE ______________

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Name ______________________________ Date _____________________

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Former Dentist ____
Date of Last Dental Visit ____
Date of Last Dental X-rays ____
How Often Do You Brush? ____
How Often Do You Floss? ____

Reason for Today's Visit: ____
____
____

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

Condition		Condition		Condition	
Bad Breath	○ Yes ○ No	Food Collection Between Teeth	○ Yes ○ No	Orthodontic Treatment	○ Yes ○ No
Bleeding Gums	○ Yes ○ No	Foreign Objects	○ Yes ○ No	Pain Around Ear	○ Yes ○ No
Blisters on Lips or Mouth	○ Yes ○ No	Grinding Teeth	○ Yes ○ No	Periodontal Treatment	○ Yes ○ No
Burning Sensation on Tongue	○ Yes ○ No	Gums Swollen or Tender	○ Yes ○ No	Sensitivity to Cold	○ Yes ○ No
Chew on One Side of Mouth	○ Yes ○ No	Jaw Pain or Tiredness	○ Yes ○ No	Sensitivity to Heat	○ Yes ○ No
Cigarette, Pipe, or Cigar Smoking	○ Yes ○ No	Lip or Cheek Biting	○ Yes ○ No	Sensitivity to Sweets	○ Yes ○ No
Clicking or Popping Jaw	○ Yes ○ No	Loose Teeth or Broken Fillings	○ Yes ○ No	Sensitivity when Biting	○ Yes ○ No
Dry Mouth	○ Yes ○ No	Mouth Breathing	○ Yes ○ No	Sores or Growths in your Mouth	○ Yes ○ No
Fingernail Biting	○ Yes ○ No	Mouth Pain, Brushing	○ Yes ○ No	Other ____________________________	

Comments: ____
____
____

GM=@E˙5 B5 @MG=G

When I see a picture of myself, the first thing I notice about my smile is:
____
____
____

Something I often notice about other smiles I consider attractive:
____
____
____

Please mark an X by any statement you agree with.

___ I wish the color of my teeth were whiter.
___ I wish I had a broader smile.
___ I think some of my teeth are too small.
___ I think some of my teeth are too large.
___ I wish my teeth were straighter.
___ I wish my bite was more comfrotable when chewing, biting.
___ I think my gums show to much when I smile.
___ I think my smile shows too much space between some of my teeth.
___ Because I am not totally pleased with my smile, I sometimes hesitate to smile.
___ I have often wished I could change some of the features of my smile.
___ I am interested in knowing the options available for a more beautiful smile.
___ Concerns over what the end result might look like, have been a factor in my not having aesthetic dentistry in my own mouth.
___ Concerns over fees have prevented me from taking advantage of some of the available options to enhance my smile.
___ I feel as though I could do a better job protecting the health of my teeth and gums, and therefore, the longevity of my own smile.

Is there anything else that you would like us to know? ____
____

Assignment of Insurance Benefits & Payment Policy

By signing the Consent for Services, you authorize direct payment to I. Bohay, M.S., D.D.S. and assume responsibility for all non-covered services or provider charges that may exceed insurance payment.

I understand that I am to pay at the time services are rendered for all charges not billable to my insurance company. I understand that it is my responsibility to pay I. Bohay, M.S., D.D.S. promptly for all services rendered regardless of any disagreement between the insurance company and myself. I understand that if my insurance company fails to pay within sixty (60) days, I. Bohay, M.S., D.D.S. will assume it to be a non-covered service and will expect me to pay.

Our payment plans are as follows:

- **Payment or copayment is required the day services are rendered.**
- **If you are unprepared to pay your balance, a $3 service fee will be charged to your account. The balance is to be paid within 2 weeks from the day of service.**
- **Returned checks are subject to a $30 NSF fee and may be subject to an additional collection fee.**
- **Balances over 30 days may be subject to additional collection fees.**
- **All accounts not paid within 90 days will automatically be sent to a collection agency.**

Accounts may be paid by Cash, Check, Visa, Mastercard, Carecredit or prior financial arrangements with the office.

Patient Participation

Patient Noncompliance

I understand that I am expected to be an active participant in my health care. Dr. Ihor Bohay has the right to terminate me from the practice if I repetitively demonstrate non-compliant, inadvisable health practices, or if I am abusive in my conduct toward Dr. Ihor Bohay or his staff.

Delinquent Account Policy

I understand that if my account becomes seriously delinquent, it may be referred to the Credit Bureau and Collections Service as provided for by the laws of this state. This may affect my credit rating for many years to come. Should this occur, I will receive a letter at home stating our policy clearly, and will be given alternatives for finding medical care elsewhere.

Missed Appointments

I understand that Dr. Ihor Bohay schedules by appointment only. I understand that if I am unable to keep an appointment I should call and cancel that appointment as soon as possible. (Ideally, we request 48 hour notice.) I also understand that if I repeatedly do not cancel or do not show up for my appointments, I will be assessed a No-Show fee of $50. *Letting us know that you cannot keep your appointment allows us to offer that time slot to another patient.*

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services not paid by insurance are charged directly to the patient and that he or she is personally responsible. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

In order to process a claim for benefits, I authorize I. Bohay, M.S., D.D.S. to release to my insurance company, any information requested regarding my dental history, symptoms, treatment, and radiographs. A photocopy of this signed release shall be considered as effective and valid as the original.

Patient Acknowledgement/Consent

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

I have had full opportunity to read and consider the contents of this form. I understand that by signing below, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit is to be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at work to discuss matters related to this form.

I have carefully read the above conditions of treatment and payment and agree to their content.

____ ________________

Signature of patient, parent, or guardian Date

Thank you for your cooperation and consideration with regard to these matters.

Dr. Ihor Bohay and Staff