

Today's Date \_\_\_ / \_\_\_ / \_\_\_

### Patient Information

**Patient Name:** \_\_\_\_\_ **Name you prefer to be called:** \_\_\_\_\_  
Last First MI

Child  Single  Married **Birth Date** \_\_\_ / \_\_\_ / \_\_\_ **Social Security# or ID#** \_\_\_\_\_  
M D Y

**Home Address:** \_\_\_\_\_ **Apartment #** \_\_\_\_\_  
Street

\_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Phone# (Home):** \_\_\_\_\_ **(Cell):** \_\_\_\_\_ **(Work):** \_\_\_\_\_ **Ext:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**Whom may we thank for referring you to our practice?** \_\_\_\_\_

### Insurance Policy Holder's Information

**Person responsible for payment for this patient:**  Self  Spouse  Parent or Guardian

**Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_  
Last First MI

**Is this person a current patient in our practice?** Y or N (If yes, Please skip to Health History form)

**Birth Date** \_\_\_ / \_\_\_ / \_\_\_ **Social Security# or ID#** \_\_\_\_\_ **Group #:** \_\_\_\_\_  
M D Y

**Home Address:** \_\_\_\_\_ **Apartment #** \_\_\_\_\_  
(If Different) Street

\_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Phone# (Home):** \_\_\_\_\_ **(Work):** \_\_\_\_\_ **Ext:** \_\_\_\_\_ **(Cell):** \_\_\_\_\_  
(If Different)

**Driver's License #** \_\_\_\_\_ **State** \_\_\_\_\_

**Policy Holder's Employer:** \_\_\_\_\_

**Dental Insurance Provider** \_\_\_\_\_ **Insurance Telephone#** \_\_\_\_\_

**Insurance Company's Address:** \_\_\_\_\_  
Street

\_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

## Health Information

Previous Dentist: \_\_\_\_\_ Approximate Date of Last Dental Visit: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check all that apply:**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS                                | <input type="checkbox"/> Dizziness                               | <input type="checkbox"/> Mental Disorders                  | <input type="checkbox"/> Tumors   |
| <input type="checkbox"/> Allergies _____                     | <input type="checkbox"/> Emphysema                               | <input type="checkbox"/> <b>Mitral Valve Prolapse</b>      | <input type="checkbox"/> Ulcers   |
| _____  | <input type="checkbox"/> Epilepsy                                | <input type="checkbox"/> Nervous Disorders                 | <input type="checkbox"/> Venereal Disease   |
| _____  | <input type="checkbox"/> Excessive Bleeding                      | <input type="checkbox"/> <b>Pacemaker</b>                  | <input type="checkbox"/> Codeine Allergy  |
| <input type="checkbox"/> Anemia                              | <input type="checkbox"/> Fainting                                | <input type="checkbox"/> Psychiatric/ Psychological Care   | <input type="checkbox"/> Penicillin Allergy   |
| <input type="checkbox"/> Arthritis                           | <input type="checkbox"/> Glaucoma                                | <input type="checkbox"/> <b>Pregnancy: Due date: _____</b> | <input type="checkbox"/> <b>Allergic/Adverse Reaction To Medication or Any Substance, Please specify:</b>     |
| <input type="checkbox"/> <b>Artificial Joints</b>            | <input type="checkbox"/> Growths                                 | <input type="checkbox"/> Radiation Treatment               | _____   |
| <input type="checkbox"/> <b>Artificial/Leaky Heart Valve</b> | <input type="checkbox"/> Hay Fever                               | <input type="checkbox"/> Respiratory Problems              | _____   |
| <input type="checkbox"/> Asthma                              | <input type="checkbox"/> H. I. V. Positive                       | <input type="checkbox"/> <b>Rheumatic Fever</b>            | <input type="checkbox"/> <b>Do you pre-medicate with antibiotics prior to dental visits? For what reason?</b> |
| <input type="checkbox"/> Blood Disease                       | <input type="checkbox"/> Head Injuries                           | <input type="checkbox"/> Rheumatism                        | _____   |
| <input type="checkbox"/> Bruise Easily                       | <input type="checkbox"/> <b>Heart (Attack, Disease, Surgery)</b> | <input type="checkbox"/> Sinus Problems                    | _____   |
| <input type="checkbox"/> Cancer                              | <input type="checkbox"/> <b>Heart Murmur</b>                     | <input type="checkbox"/> Smoke/Chew Tobacco                | _____   |
| <input type="checkbox"/> Cold Sores/Fever Blisters           | <input type="checkbox"/> Hemophilia                              | <input type="checkbox"/> Stomach Problems                  | _____   |
| <input type="checkbox"/> Contact Lenses                      | <input type="checkbox"/> Hepatitis                               | <input type="checkbox"/> Stroke                            | _____   |
| <input type="checkbox"/> Cortisone Medication                | <input type="checkbox"/> <b>High Blood Pressure</b>              | <input type="checkbox"/> Thyroid Problems                  | _____   |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Jaundice                                | <input type="checkbox"/> Tuberculosis                      |   |
| <input type="checkbox"/> Diet: (Special/ Restricted)         | <input type="checkbox"/> Kidney Disease                          |  |   |
|  | <input type="checkbox"/> <b>Latex Sensitivity</b>                |  |   |
|  | <input type="checkbox"/> Liver Disease                           |  |   |

• Have you ever taken any of the following osteoporosis medications: Zometá, Aredia, Fosamax or Actonel? \_\_\_ Yes \_\_\_ No

• Have you ever had any complications following dental treatment? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Do you have any health problems that need further clarification? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

• Are you taking any medications? Purpose? Please list \_\_\_\_\_

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

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_

## Cancellation of Appointments

**I agree to keep all scheduled appointments unless I notify the office at least 48 hours prior to the appointment. I understand that failure to keep a scheduled appointment may result in a missed appointment fee of \$40 per hour scheduled. If we are able to fill your appointment spot with less notice we will not charge you.**

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_

## Consent for Services and Financial Information and HIPAA Information

### **Consent:**

I hereby authorize Dr. Boeyink and/or his staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Boeyink to make a thorough diagnosis of my current dental needs. Upon such diagnosis, I authorize Dr. Boeyink to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. 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.

**I understand, acknowledge, and agree that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes. I further understand that my name or identifying information will be kept confidential.**

### **Financial Information:**

As a courtesy, this office will help prepare and submit your insurance forms, however I understand that any fees not covered by insurance are my final responsibility. By signing this form I authorize this office to submit insurance claims and to contact my insurance company on my behalf. In consideration for the professional services rendered to me or at my request, I agree to pay for all services regardless of insurance coverage.

**I understand that any fee estimate provided by this office for my dental care is only extended for a period of ninety (90) days from the date of the patient examination.**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment 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 any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. A service charge of 18% per year will be charged to my account on any unpaid balance not paid the day of service, unless previously written financial arrangements are made. I understand that payment plans are available to assist with payment. I understand that in order to be approved for any payment plan options that a credit report may be run. By signing this form I authorize a credit check to be administered if I am asking for credit to be extended to me.

I understand that in the event that I default in the payment of fees due to Dr. Boeyink, I will be responsible for all expenses incurred by Dr. Boeyink including, but not limited to attorney fees, collection expenses, discretionary costs and court costs associated with collecting outstanding fees. I also understand that negative payment information may be reported to credit agencies.

### **HIPAA Information:**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g. my insurance company); the day-to-day healthcare operations of your practice. I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care options, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

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

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

\_\_\_\_\_  
Signature of patient, parent or guardian

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_