Kevin M. Bogdon DDS Dental Excellence with a Personal Touch!

Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

F-mail Address	Last Name:		First Nam	ne:
	, Mailing Address:			
			Home Phon	e:,
	, Driver's License:			
•				
	, Addre			
			the state of the s	
	n above):			
Spouse's Employer:		Address, City, State, Zip:		
To the agent that we must good a	ct you for scheduling changes, etc	nlesse indicate the best PHC	ONE NUMBER during bu	siness hours to phone you:
				Time:
Phone number:		3		
How did you hear about our office	e? Please check:Internet Sea	arch Patient referral	AdAd	Yellow Pages Other
If you were referral whom may	we thank for their trust in us?			
INSURANCE	INFORMATI	ON:		
Primary Insurance Company :		Address:		
				Birth date:
	되기 그 이번 그렇게 뭐 그 하는데			
Group# or Policy#				
treatment. This release is so	laby for the nurnose of facility	iting the billing and reimb am financially responsible	ursement, directly to K for all treatment rende	ls of examinations, diagnosis and/or evin M. Bogdon DDS of insurance ered, and understand that complete nged.
Date:	Patient's Signature	•		
CONSENT:				
I hereby authorize Kevin M. I Kevin M. Bogdon DDS to ma of treatment, medication and dental insurance is a contract	ike a thorough diagnosis of the the	patient's dental needs. I als I also understand the use of carrier and not between Kev	o authorize Kevin M. Bo anesthetic agents embod in M. Bogdon DDS and	liagnostic aids deemed appropriate by gdon DDS to perform any and all forties a certain risk. I understand that my your insurance company. I fully
Betient Cionatura:		Date:	Dr. Signature:	international design of the first of the contract of the contr

FINANCIAL ARRANGEMENT AGREEMENT

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment at the time of your treatment is considered a part of your commitment to our office.

In order to be impartial to everyone, PAYMENT IS REQUIRED AT THE TIME OF TREATMENT. We ask that you read and sign along with us, this statement prior to any treatment. Should you have any insurance benefits that we will be filing for you. YOUR CO-PAY AND DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF TREATMENT. We accept cash, check, debit cards as well as VISA/MASTERCARD AND DISCOVER CARD. For extensive treatment plans, we offer extended payment plans with our Dental Plan options at either little or No interest with prior credit approval.

REGARDING INSURANCE

We will gladly file all dental claims for the given treatment programs or contracts. The balance is **YOUR** responsibility whether your insurance carrier pays your treatment or not. It is **YOUR** responsibility, that after **45** days without payment from your insurance carrier, the **TOTAL** balance due on the account is owed by you.

MISSED APPOINTMENTS

In order to be fair to all our patients, we ask that you notify our office at least 2 Working Days in advance should you have conflict with your scheduled appointment. Failure to contact the office or doctor will result with a charge of an office visit.

FINANCE CHARGES

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that thins finance charge is equal to 1.5% of my outstanding balance per month. I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Kevin M. Bogdon DDS must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Kevin M. Bogdon DDS.

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Financial Coordinator:	and the second of the second o	Date:	
Patient Signature:		Date:	

Are No Are you being treated by a physician now? For what? Name of your physician:				Are you in good health? Has there been a change in your health within the last year?		11			
Amne of your physician: Date of last Medical Exam: 3. HAVE YOU EVER EXPERIENCED? 5. Yes No Chest Pains 5. Yes No Chest Pains 6. Yes No Swollen Ankles 7. Yes No Swollen Ankles 7. Yes No Shortness of breath 8. Yes No Shortness of breath 8. Yes No Recent weight loss, fever, night sweats 8. Yes No Recent weight loss, fever, night sweats 9. Yes No Persistent cough, coughing up blood 9. Yes No Bleeding problems, bruising easily 9. Yes No Bleeding problems, bruising easily 9. Yes No Situs Problems 9. 21. Yes No Seizures 9. Yes No Difficulty swallowing 9. Yes No Dimit pain, stiffness 9. Yes No Joint pain, stiffness 9. Yes No Heart attack, heart defects, 9. Yes No Heart attack, heart defects, 9. Yes No Heart attack, heart defects, 9. Yes No Heart murnur 9. Yes No Heart murnur 9. Yes No Rheumatic fever 9. Yes No Stroke, hardening of arteries 9. Yes No Stroke, hardening of arteries 9. Yes No The, emphysema or other lung diseases 9. Yes No The, emphysema or other lung diseases 9. Yes No Diabetes 9. Yes No Diabetes 9. Yes No Diabetes 9. Yes No Mitral Valve Prolapse 9. Yes No More Contact Lenses 9. Yes No Tobacco in any forms 1. Yes No Posamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:	3.	Yes	No	Have you been hospitalized or had a serious illness in the la	ast 5 years	? E	kplain:		
3. HAVE YOU EVER EXPERIENCED? 5. Yes No Chest Pains 5. Yes No Chest Pains 6. Yes No Swollen Ankles 7. Yes No Swollen Ankles 7. Yes No Swollen Ankles 8. Yes No Shortness of breath 8. Yes No Persistent cough, coughing up blood 9. Yes No Bleeding problems, bruising easily 9. Yes No Bliffeulty swallowing 9. Yes No Difficulty swallowing 9. Yes No Joint pain, stiffness 9. Yes No Jundice 9. Yes No Jundice 9. Yes No Jundice 9. Yes No Heart attack, heart defects, 9. Yes No Heart attack, heart defects, 9. Yes No Heart murmur 9. Yes No Heart murmur 9. Yes No Heart murmur 9. Yes No Stroke, hardening of arteries 9. Yes No Stroke, hardening of arteries 9. Yes No The, emphysema or other lung diseases 9. Yes No The, emphysema or other lung diseases 9. Yes No Mitral Valve Prolapse 9. Yes No Psychiatric Care 9. Yes No No Currently taking Birth Control Pills 9. Yes No No Currently Pregnant or nursing 9. Yes No No Currently Pregnant or nursing 9. Yes No No Doaco in any forms 9. Yes No No Psychiatric Care 9. Yes No Psychiatric Care 9. Yes No No Psychiatric Care 9. Yes No Psychiatric	4.	Yes	No	Are you being treated by a physician now? For what?					
1. Yes No Chest Paims 15. Yes No Dizziness	Na	me of	your	· physician:	Date o	f la	st Med	lical E	xam:
5. Yes No Swollen Ankles 7. Yes No Shortness of breath 8. Yes No Recent weight loss, fever, night sweats 8. Yes No Recent weight loss, fever, night sweats 9. Yes No Persistent cough, coughing up blood 19. Yes No Bleeding problems, bruising easily 10. Yes No Bleeding problems, bruising easily 10. Yes No Bleeding problems, bruising easily 10. Yes No Difficulty swallowing 10. Yes No Heart attack, heart defects, 10. Yes No Heart attack, heart defects, 10. Yes No Heart murmur 10. Yes No Heart murmur 10. Yes No Heart murmur 10. Yes No Recurrent fever 10. Yes No Recurrent fever 10. Yes No High Blood Pressure 11. Yes No Tab, enphysema or other lung diseases 12. Yes No Heart disease 13. Yes No Stonach problems, ulcers 14. Yes No Heart disease 14. Yes No Heapatitis, A B C 14. Yes No Stomach problems, ulcers 14. Yes No Heapatitis, A B C 14. Yes No Stomach problems, ulcers 14. Yes No Heapatitis, A B C 14. Yes No Stomach problems, ulcers 14. Yes No Heapatitis, A B C 14. Yes No Stomach problems, ulcers 14. Yes No Heapatitis, A B C 15. Yes No Stomach problems, ulcers 16. Yes No Heapatitis, A B C 17. Yes No Stomach problems, ulcers 18. Yes No Heapatitis, A B C 18	В.	HA	VE Y	YOU EVER EXPERIENCED?					
Yes No Shortness of breath 17. Yes No Frequent Headaches	5.	Yes	No	Chest Pains		15.	Yes	No	Dizziness
3. Yes No Recent weight loss, fever, night sweats 18. Yes No Painting spells 19. Yes No Persistent cough, coughing up blood 19. Yes No Bleding problems, bruising easily 20. Yes No Simus Problems 21. Yes No Excessive thirst 21. Yes No Difficulty swallowing 22. Yes No Dry Mouth 24. Yes No Joint pain, stiffness 23. Yes No Dry Mouth 24. Yes No Sleep apnea or chronic snoring 25. Yes No Heart attack, heart defects, 37. Yes No Heart matter attack, heart defects, 37. Yes No Reternation of arteries 39. Yes No Stroke, hardening of arteries 40. Yes No High Blood Pressure 41. Yes No Anemia 40. Yes No Skin disease 42. Yes No Hepatitis, A B C 43. Yes No Hepatitis, A B C 43. Yes No Diabetes 44. Yes No Diabetes 45. Yes No Diabetes 45. Yes No Mitral Valve Prolapse 46. Yes No Mitral Valve Prolapse 46. Yes No History of diabetes, heart problems, 27. Yes No Psychiatric Care 55. Yes No Psychiatric Care 56. Yes No Prostnetic heart valve 57. Yes No Psychiatric Care 56. Yes No Prostnetic heart valve 57. Yes No Contact Lenses 57. Yes No Prostnetic heart valve 57. Yes No Contact Lenses 57. Yes No Prostnetic heart valve 57. Yes No Prostnetic heart valve 57. Yes No Phen Phen diet Pills or any other diet pills 57. Yes No Fosamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:			No					No	
1. Yes No Persistent cough, coughing up blood 19. Yes No Shirred Vision									
New No Bleeding problems, bruising easily 20. Yes No Seizures								No	
Yes No Simus Problems 21. Yes No Excessive thirst									
2. Yes No Difficulty swallowing 3. Yes No Joint pain, stiffness 2. Yes No Joint pain, stiffness 2. Yes No Joint pain, stiffness 2. Yes No Dry Mouth 3. Yes No Jaundice 2. Yes No Sleep apnea or chronic snoring 2. Yes No Sleep apnea or chronic snoring 2. Yes No Heart disease 3. Yes No Heart attack, heart defects, 3. Yes No Heart mature 3. Yes No Heart mature 3. Yes No Rheumatic fever 3. Yes No Rheumatic fever 3. Yes No Stroke, hardening of arteries 4. Yes No High Blood Pressure 4. Yes No Warehald Stroke, hardening of arteries 4. Yes No Stroke, hardening of arteries 4. Yes No Hepatitis, A B C 4. Yes No Hepatitis, A B C 4. Yes No Herpes 4. Yes No Stomach problems, ulcers 4. Yes No Mitral Valve Prolapse 5. Yes No Surgeries 5. Yes No Contact Lenses 5. Yes No Contact Lenses 5. Yes No Contact Lenses 5. Yes No Pacernaker 5. Yes No Prosthetic heart valve 5. Yes No Prosthetic heart valve 5. Yes No Prosthetic heart valve 5. Yes No Recreational drugs 7. Yes No Recreational drugs 7. Yes No Prostendic normal profits 7. Yes No Currently Pregnant or nursing 7. Yes No Prostendic normal profits 7. Yes No Prostendic n									
3. Yes No Joint pain, stiffness 23. Ves No Dry Mouth 24. Yes No Sleep apnea or chronic snoring 24. Yes No Dry Mouth 24. Yes No Sleep apnea or chronic snoring 25. Yes No Heart disease 36. Yes No Heart attack, heart defects, 37. Yes No Tumors, Cancer Tumors, Cancer 39. Yes No Rheumatic fever 39. Yes No Eye disease 40. Yes No Stroke, hardening of arteries 40. Yes No Skin disease 41. Yes No Anemia 41. Yes No Hepatitis, A B C 43. Yes No Hepatitis, A B C 43. Yes No Hepatitis, A B C 44. Yes No Hepatitis, A B C 44. Yes No Hepatitis, A B C 45. Yes No Mitral Valve Prolapse 46. Yes No Mitral Valve Prolapse 46. Yes No History of diabetes, heart problems, D. DO YOU HAVE OR HAVE YOU HAD: 7. Yes No Surgeries 52. Yes No Artificial Joint 54. Yes No Artificial Joint 54. Yes No Psychiatric Care 56. Yes No Currently taking Birth Control Pills 79. Yes No Recreational drugs 9. Yes No Recreational drugs 9. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pills 3. Yes No Phen Phen diet Pills or any other diet pi									
1. Yes No Jaundice 24. Yes No Sleep apnea or chronic snoring C. DO YOU HAVE OR HAVE YOU HAD: 5. Yes No Heart disease 36. Yes No Tumors, Cancer 7. Yes No Heart murmur 38. Yes No Tumors, Cancer 39. Yes No Heart murmur 38. Yes No Arthritis, rheumatism 8. Yes No Stroke, hardening of arteries 40. Yes No Stroke, hardening of arteries 41. Yes No Anemia 42. Yes No Hepatitis, A B C 43. Yes No Hepatitis, A B C 43. Yes No Edidney, bladder diseases 44. Yes No Kidney, bladder diseases 45. Yes No Mitral Valve Prolapse 45. Yes No Mitral Valve Prolapse 46. Yes No History of diabetes, heart problems. D. DO YOU HAVE OR HAVE YOU HAD: 7. Yes No Contact Lenses 5. Yes No Contact Lenses 5. Yes No Contact Lenses 5. Yes No Psychiatric Care 56. Yes No Currently taking Birth Control Pills 57. Yes No Recreational drugs 9. Yes No Postmax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies: 36. Yes No Piagnea or chronic snoring 36. Yes No Pacemaker 1. The proof of the properties of									
C. DO YOU HAVE OR HAVE YOU HAD: 5. Yes No Heart disease 36. Yes No Heart attack, heart defects, 37. Yes No Tumors, Cancer 7. Yes No Heart murmur 38. Yes No Arthritis, rheumatism 8. Yes No Rheumatic fever 39. Yes No Eye disease 9. Yes No Stroke, hardening of arteries 40. Yes No Skin disease 10. Yes No High Blood Pressure 41. Yes No Anemia 11. Yes No TB, emphysema or other lung diseases 42. Yes No VD (syphilis or gonorrhea) 12. Yes No Hepatitis, A B C 43. Yes No Herpes 13. Yes No Stomach problems, ulcers 44. Yes No Kidney, bladder diseases 14. Yes No Diabetes 45. Yes No Thyroid, adrenal diseases 15. Yes No Mitral Valve Prolapse 46. Yes No History of diabetes, heart problems, 16. DO YOU HAVE OR HAVE YOU HAD: 17. Yes No Surgeries 52. Yes No Chemotherapy 18. Yes No Prosthetic heart valve 19. Yes No Contact Lenses 55. Yes No Prosthetic heart valve 19. Yes No Psychiatric Care 55. Yes No Currently taking Birth Control Pills 19. Yes No Recreational drugs 19. Yes No Alcohol 19. Yes No Fosamax 10. Lergies: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:									
5. Yes No Heart attack, heart defects, 7. Yes No Heart attack, heart defects, 7. Yes No Heart attack, heart defects, 7. Yes No Heart murnur 8. Yes No Rheumatic fever 9. Yes No Stroke, hardening of arteries 9. Yes No High Blood Pressure 11. Yes No High Blood Pressure 12. Yes No TB, emphysema or other lung diseases 13. Yes No Hepatitis, A B C 14. Yes No Hepatitis, A B C 15. Yes No Stomach problems, ulcers 16. Yes No Diabetes 17. Yes No Diabetes 18. Yes No Mitral Valve Prolapse 19. Yes No Mitral Valve Prolapse 19. Yes No Blood Transfusions 19. Yes No Blood Transfusions 19. Yes No Contact Lenses 10. Yes No Contact Lenses 10. Yes No Recreational drugs 10. Yes No Recreational drugs 10. Yes No Tobacco in any forms 10. Yes No Phen Phen diet Pills or any other diet pills 10. Yes No Phen Phen diet Pills or any other diet pills 10. Yes No Phen Phen diet Pills or any other diet pills 10. Yes No Phen Phen diet Pills or any other diet pills 10. Yes No Phen Phen diet Pills or any other diet pills 11. Yes No Phen Phen diet Pills or any other diet pills 12. Yes No Phen Phen diet Pills or any other diet pills 13. Yes No Phen Phen diet Pills or any other diet pills 14. Yes No Phen Phen diet Pills or any other diet pills 15. Yes No Phen Phen diet Pills or any other diet pills 16. Yes No Phen Phen diet Pills or any other diet pills 17. Yes No Phen Phen diet Pills or any other diet pills 18. Yes No Phen Phen diet Pills or any other diet pills 19. Yes No Phen Phen diet Pills or any other diet pills 19. Yes No Phen Phen diet Pills or any other diet pills 19. Yes No Phen Phen diet Pills or any other diet pills 19. Yes No Phen Phen diet Pills or any other diet pills 19. Yes No Phen Phen diet Pills or any other diet pills 19. Yes No Phen Phen diet Pills or any other diet pills 19. Yes No Phen Phen diet Pills or any other diet pills 19. Yes No Phen Phen diet Pills or any other diet pills 19. Yes No Phen Phen diet Pills or any other diet pills 1	ŧ.	y es	NO	Jaundice		<i>2</i> 4.	Y es	INO	Steep apnea or chronic shoring
5. Yes No Heart attack, heart defects, 7. Yes No Heart murmur 7. Yes No Heart murmur 7. Yes No Rheumatic fever 7. Yes No Rheumatic fever 7. Yes No Stroke, hardening of arteries 7. Yes No Stroke, hardening of arteries 7. Yes No Stroke, hardening of arteries 7. Yes No High Blood Pressure 7. Yes No Hepatitis, A B C 7. Yes No Diabetes 7. Yes No Diabetes 7. Yes No Mitral Valve Prolapse 7. Yes No Mitral Valve Prolapse 7. Yes No Mitral Valve Prolapse 7. Yes No Surgeries 7. Yes No Surgeries 7. Yes No Surgeries 7. Yes No Surgeries 7. Yes No Contact Lenses 7. Yes No Contact Lenses 7. Yes No Psychiatric Care 7. Yes No Psychiatric Care 7. Yes No Recreational drugs 7. Yes No Recreational drugs 7. Yes No Tobacco in any forms 7. Yes No Tobacco in any forms 7. Yes No Tobacco in any forms 7. Yes No Phen Phen diet Pills or any other diet pills 7. Yes No Fosamax 7. Yes No Heart murmur 7. Yes No Fosamax 7. Yes No Hepatitis, heumatism 7. Yes No Hepatitis, heumatism 7. Yes No Tobacco in any forms 7. Yes No Tobacco in any forms 7. Yes No Tobacco in any forms 8. Yes No Fosamax 7. Yes No Fos						36	V-	NT.	LIIV monitive AIDC ABC
7. Yes No Heart murmur 38. Yes No Arthritis, rheumatism 39. Yes No Rheumatic fever 39. Yes No Stroke, hardening of arteries 40. Yes No Skin disease 40. Yes No Skin disease 41. Yes No Anemia 42. Yes No Anemia 42. Yes No Anemia 43. Yes No Hepatitis, A B C 43. Yes No History of diabetes 45. Yes No Thyroid, adrenal diseases 45. Yes No Thyroid, adrenal diseases 45. Yes No Thyroid, adrenal diseases 46. Yes No History of diabetes, heart problems, 46. Yes No Artificial Joint 54. Yes No Prosthetic heart valve 55. Yes No Prosthetic heart valve 56. Yes No Pacemaker 56. Yes No Currently regnant or nursing 57. Yes No Currently Pregnant or nursing 57. Yes No Recreational drugs 57. Yes No Phen Phen diet Pills or any other diet pills 79. Yes No Phen Phen diet Pills or any other diet pills 79. Yes No Phen Phen diet Pills or any other diet pills 79. Yes No Phen Phen diet Pills or any other diet pills 79. Yes No Phen Phen diet Pills or any other diet pills 79. Yes No Phen Phen diet Pills or any other diet pills 79. Yes No 70 dacco in any forms 79. Yes No 7									
39. Yes No Rheumatic fever 39. Yes No Eye disease 39. Yes No Eye disease 39. Yes No Stroke, hardening of arteries 39. Yes No Stroke, hardening of arteries 39. Yes No Stroke, hardening of arteries 40. Yes No High Blood Pressure 41. Yes No Anemia 42. Yes No VD (syphilis or gonorrhea) 43. Yes No Hepatitis, A B C 43. Yes No Hepatitis, A B C 44. Yes No Kidney, bladder diseases 45. Yes No Diabetes 46. Yes No Thyroid, adrenal diseases 47. Yes No Diabetes 48. Yes No Mitral Valve Prolapse 49. Yes No Mitral Valve Prolapse 40. Yes No Radiation Treatments 40. Yes No Surgeries 41. Yes No Surgeries 42. Yes No Radiation Treatments 43. Yes No Radiation Treatments 44. Yes No Radiation Treatments 45. Yes No Chemotherapy 46. Yes No Radiation Treatments 47. Yes No Surgeries 48. Yes No Chemotherapy 49. Yes No Contact Lenses 49. Yes No Posthetic heart valve 40. Yes No Posthetic heart valve 41. Yes No Posthetic heart valve 42. Yes No Radiation Treatments 43. Yes No Radiation Treatments 44. Yes No Radiation Treatments 45. Yes No Chemotherapy 46. Yes No Chemotherapy 47. Yes No Contact Lenses 48. Yes No Posthetic heart valve 49. Yes No Posthetic heart valve 40. Yes No Posthetic heart valve 41. Yes No Posthetic heart valve 41. Yes No Posthetic heart valve 41. Yes No Posthetic heart valve 42. Yes No Radiation Treatments 43. Yes No Radiation Treatments 44. Yes No Radiation Treatments 45. Yes No Chemotherapy 46. Yes No Chemotherapy 47. Yes No Chemotherapy 48. Yes No Chemotherapy 49. Yes No Posthetic Learner 49. Yes No Posthetic Care 40. Yes No Currently taking Birth Control Pills 57. Yes No Currently Pregnant or nursing 58. Yes No Recreational drugs 59. Yes No Alcohol 50. Yes No Posthetic Care 50. Yes No Posthetic Care 51. Yes No Posthetic Care 52. Yes No Posthetic Care 53. Yes No Recreational drugs 54. Yes No Posthetic Care 55. Yes No Currently taking Birth Control Pills 57. Yes No Posthetic Care 59. Yes No Post									
New No Stroke, hardening of arteries 40. Yes No Skin disease									
No									
1. Yes No TB, emphysema or other lung diseases 42. Yes No Heppes 43. Yes No Heppes 44. Yes No Kidney, bladder diseases 44. Yes No Kidney, bladder diseases 45. Yes No Diabetes 45. Yes No Mitral Valve Prolapse 46. Yes No History of diabetes, heart problems, on the problems of the problem									
2. Yes No Hepatitis, A B C 3. Yes No Stomach problems, ulcers 4. Yes No Diabetes 4. Yes No Diabetes 4. Yes No Diabetes 5. Yes No Mitral Valve Prolapse 4. Yes No Herpes 4. Yes No Thyroid, adrenal diseases 4. Yes No History of diabetes, heart problems, 4. Yes No History of diabetes, heart problems, 4. Yes No Surgeries 5. Yes No Radiation Treatments 5. Yes No Radiation Treatments 5. Yes No Prosthetic heart valve 6. Yes No Prosthetic heart valve 7. Yes No Contact Lenses 7. Yes No Psychiatric Care 7. Yes No Psychiatric Care 7. Yes No Psychiatric Care 7. Yes No Recreational drugs 7. Yes No Recreational drugs 7. Yes No Tobacco in any forms 7. Yes No Phen Phen diet Pills or any other diet pills 7. Yes No Fosamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:									
3. Yes No Stomach problems, ulcers 44. Yes No Lidney, bladder diseases 45. Yes No Diabetes 45. Yes No Mitral Valve Prolapse 46. Yes No History of diabetes, heart problems, 45. Yes No Mitral Valve Prolapse 46. Yes No History of diabetes, heart problems, 46. Yes No History of diabetes, heart problems, 46. Yes No Radiation Treatments 57. Yes No Blood Transfusions 57. Yes No Chemotherapy 57. Yes No Artificial Joint 57. Yes No Prosthetic heart valve 57. Yes No Psychiatric Care 57. Yes No Currently taking Birth Control Pills 57. Yes No Currently Pregnant or nursing 57. Yes No Recreational drugs 59. Yes No Recreational drugs 59. Yes No Phen Phen diet Pills or any other diet pills 59. Yes No Fosamax 1. Yes No Fosamax 1. LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:		4							
4. Yes No Diabetes Mitral Valve Prolapse 45. Yes No Mitral Valve Prolapse 46. Yes No Mitral Valve Prolapse 46. Yes No History of diabetes, heart problems, but the first of the problems of the first of the problems of the p				Carried model and address					
Mitral Valve Prolapse 46. Yes No History of diabetes, heart problems,									
7. Yes No Surgeries									History of diabetes, heart problems,
7. Yes No Surgeries	D.	DO	YO	U HAVE OR HAVE YOU HAD:					
9. Yes No Artificial Joint 54. Yes No Prosthetic heart valve 55. Yes No Pacemaker 55. Yes No Pacemaker 56. Yes No Currently taking Birth Control Pills 57. Yes No Currently Pregnant or nursing 57. Yes No Currently Pregnant or nursing 58. Yes No Recreational drugs 59. Yes No Alcohol 50. Yes No Tobacco in any forms 50. Yes No Phen Phen diet Pills or any other diet pills 50. Yes No Fosamax 50. MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:	7.	Yes	No	Surgeries		52.	Yes	No	Radiation Treatments
9. Yes No Artificial Joint 54. Yes No Prosthetic heart valve 55. Yes No Pacemaker 55. Yes No Pacemaker 56. Yes No Currently taking Birth Control Pills 57. Yes No Currently Pregnant or nursing 57. Yes No Currently Pregnant or nursing 58. Yes No Recreational drugs 59. Yes No Alcohol 50. Yes No Tobacco in any forms 50. Yes No Phen Phen diet Pills or any other diet pills 50. Yes No Fosamax 50. MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:	8.	Yes	No	Blood Transfusions		53.	Yes	No	Chemotherapy
1. Yes No Contact Lenses 1. Yes No Psychiatric Care 2. So. Yes No Pacemaker 2. So. Yes No Currently taking Birth Control Pills 2. Yes No Recreational drugs 3. Yes No Recreational drugs 3. Yes No Recreational drugs 3. Yes No Tobacco in any forms 4. Yes No Phen Phen diet Pills or any other diet pills 5. Yes No Fosamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:	9.	Yes	No	Artificial Joint	4.0	54.	Yes	No	Prosthetic heart valve
E. DO YOU TAKE OR HAVE TAKEN: 8. Yes No Recreational drugs 9. Yes No Tobacco in any forms 1. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Fosamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:	0.	Yes	No	Contact Lenses		55.	Yes	No	Pacemaker
E. DO YOU TAKE OR HAVE TAKEN: S. Yes No Recreational drugs O. Yes No Tobacco in any forms I. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Fosamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:						56.	Yes	No	Currently taking Birth Control Pills
8. Yes No Recreational drugs 9. Yes No Alcohol 10. Yes No Tobacco in any forms 11. Yes No Phen Phen diet Pills or any other diet pills 12. Yes No Fosamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:						57.	Yes	No	Currently Pregnant or nursing
9. Yes No Alcohol 10. Yes No Tobacco in any forms 11. Yes No Phen Phen diet Pills or any other diet pills 12. Yes No Fosamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:						F. V	VITA	MINS	& MEDICATIONS:
O. Yes No Tobacco in any forms O. Yes No Phen Phen diet Pills or any other diet pills O. Yes No Fosamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:									
1. Yes No Phen Phen diet Pills or any other diet pills 2. Yes No Fosamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:								<u> </u>	
2. Yes No Fosamax LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:								in the second	
LLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:							1,1	. 15 151	
	2.	Yes	No	Fosamax	TALS, JE	WI	ELRY	, ACR	YLICS, ETC, please list allergies
일반 1일 등 기계를 가장하는 것이 되었다. 그 사람들이 되는 것이 되는 것이 되는 것이 되었다. 그렇게 되었다. 그렇게 되었다. 그렇게 되었다. 									
G. ALL PATIENTS:	G	ΑI	L PA	ATIENTS:					

64. Yes No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?

DENTAL HEALTH HISTORY

Н.	Name of your Former Dentist:		How long since you were last seen?
65	Is keeping your teeth important to you? [Y]	INI If was why?	
	On a scale of 1-10, 10 being the best, where		
67.			
68.	Have you experienced any of the following p	problems:	
	Bleeding gums [Y] [N],		Sensitivity to Hot & Cold [Y] [N]
	Bad Breath or sour taste in mouth [Y] [N]		Snoring [Y] [N]
	Burning sensations in mouth [Y] [N]		Food catching between teeth [Y] [N]
	Soreness in jaw [Y] [N],		Clenching or Grinding of Teeth [Y] [N]
	Is it hard for you to open wide? [Y] [N]		Pain/soreness around ears, eyes, face [Y] [N]
	Clicking or popping in jaw [Y] [N]		Stiff neck muscles [Y] [N]
	Have you or your parents suffer(ed) from Gur	n Disease? [Y] [N]	Do you or your parents wear dentures/partials? [Y] [N]
	Did you ever wear braces? [Y] [N]		Ever been injured in your mouth or head? [Y] [N]
	Oral Surgery of any kind? [Y] [N]		Do you smoke or chew tobacco? [Y] [N]
70	Does having dental treatment make you afraid	or pervous? [V][N] If yes	what enacifie things bother you?
70.	Does having dental treatment make you affaid	or nervous: [1][14] 11 yes	what specific things bother you.
/1.	Is the brightness of your teeth important to you	1? [Y] [N]	
72.	If you could change anything about your smile	which of the following wor	ıld you want?
	Whiter [Y] [N]	Close space or spaces [Y]	[N] Replace chipped teeth [Y] [N]
	Replace missing teeth [Y] [N]	Replace old crowns [Y]	[N] Remove silver fillings [Y] [N]
	Remove Stains/Spots on teeth [Y] [N]	Excess showing of Teeth	Y] [N] Replace old plastic filling(s) [Y] [N
	Straighter [Y] [N]	Less Gum showing [Y] [N] Reshape/resize my teeth [Y [N]
73	Fill in this question for us please. Where	e do vou see vour overall	oral health and/or your smile in the next 5 to 10 years?
, 5.			
74	. Please circle the following which a	re important to you v	hen making your dental health decision.
	진데 하는 만짓밤 표현 모상 다 모양		
	Convenience	Appearance	Relationship with Dental Team
	Finances Time What insurance covers Health		Quality of care
			Detailed treatment explanations
	Fear or Anxiety	Comfort	Technology
Pa	atient Signature:		Date:

Notic f Privacy Practices Acknowle ement Kevin M. Bogdon DDS 523 E. Glenoaks Blvd Glendale, Ca. 91207 Tel:818-243-5227 Fax:(818) 409 9261

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:		 -
Relationship to Patient:		
Signature:		
Date:	•	 .
	,	
	Office Use Only	

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date Initials Reason