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:

E-mail Address: _____, Last Name: _____ First Name: _____

Preferred to be called: _____, Mailing Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____,

City, State, Zip: _____ Date of Birth: _____

SS#: _____, Driver's License: _____ Sex: M F Occupation: _____

Employer: _____, Address, City State, Zip _____

Emergency Contact Name: _____ Phone # : _____

Spouse's Name: _____ Occupation: _____

Spouse's Address (if different than above): _____, City, State, Zip: _____

Spouse's Employer: _____ Address, City, State, Zip: _____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: _____, **Place**_____ **Time:** _____

How did you hear about our office? Please check: _____Internet Search ____Patient referral ____Website _____Ad _____Yellow Pages Other _____

If you were referral whom may we thank for their trust in us? _____

INSURANCE INFORMATION:

Primary Insurance Company : _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy Holder Name: _____:Member's ID# _____ Birth date: _____

Group# or Policy # _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Kevin M. Bogdon DDS of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: _____ **Patient's Signature:** _____

CONSENT:

I hereby authorize Kevin M. Bogdon DDS to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Kevin M. Bogdon DDS to make a thorough diagnosis of the patient's dental needs. I also authorize Kevin M. Bogdon DDS to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Kevin M. Bogdon DDS and your insurance company. I fully understand that it is my responsibility only for all dental treatment regardless of insurance coverage.

Patient Signature: _____ Date: _____ Dr. Signature: _____

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: _____ Date: _____

Patient Signature: _____ Date: _____

MEDICAL HEALTH HISTORY **PATIENT NAME:** _____ **Date:** _____

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain: _____
3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain: _____

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4. Yes No Are you being treated by a physician now? For what? _____

Name of your physician: _____ Date of last Medical Exam: _____

B. HAVE YOU EVER EXPERIENCED?

5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Joint pain, stiffness
14. Yes No Jaundice
15. Yes No Dizziness
16. Yes No Ringing in ears
17. Yes No Frequent Headaches
18. Yes No Fainting spells
19. Yes No Blurred Vision
20. Yes No Seizures
21. Yes No Excessive thirst
22. Yes No Frequent urination
23. Yes No Dry Mouth
24. Yes No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD:

25. Yes No Heart disease
26. Yes No Heart attack, heart defects,
27. Yes No Heart murmur
28. Yes No Rheumatic fever
29. Yes No Stroke, hardening of arteries
30. Yes No High Blood Pressure
31. Yes No TB, emphysema or other lung diseases
32. Yes No Hepatitis, A B C
33. Yes No Stomach problems, ulcers
34. Yes No Diabetes
35. Yes No Mitral Valve Prolapse
36. Yes No HIV positive or AIDS-ARC
37. Yes No Tumors, Cancer
38. Yes No Arthritis, rheumatism
39. Yes No Eye disease
40. Yes No Skin disease
41. Yes No Anemia
42. Yes No VD (syphilis or gonorrhea)
43. Yes No Herpes
44. Yes No Kidney, bladder diseases
45. Yes No Thyroid, adrenal diseases
46. Yes No History of diabetes, heart problems, cancer

D. DO YOU HAVE OR HAVE YOU HAD:

47. Yes No Surgeries _____
48. Yes No Blood Transfusions _____
49. Yes No Artificial Joint _____
50. Yes No Contact Lenses _____
51. Yes No Psychiatric Care _____
52. Yes No Radiation Treatments
53. Yes No Chemotherapy
54. Yes No Prosthetic heart valve
55. Yes No Pacemaker
56. Yes No Currently taking Birth Control Pills
57. Yes No Currently Pregnant or nursing

E. DO YOU TAKE OR HAVE TAKEN:

58. Yes No Recreational drugs
59. Yes No Alcohol
60. Yes No Tobacco in any forms
61. Yes No Phen Phen diet Pills or any other diet pills
62. Yes No Fosamax

F. VITAMINS & MEDICATIONS: _____

_____

_____

ALLERGIES: LATEX, ANY DRUGS, FOODS, MEDICATIONS, METALS, JEWELRY, ACRYLICS, ETC, please list allergies:

G. ALL PATIENTS:

63. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

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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

H. Name of your Former Dentist: _____ **How long since you were last seen?** _____

65. Is keeping your teeth important to you? [Y] [N] If yes, why? _____
66. On a scale of 1-10, 10 being the best, where would you rate your smile?
67. On a scale of 1-10, 10 being the best, where you rate your oral health?
68. Have you experienced any of the following 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 Gum 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 nervous? [Y] [N] If yes, what specific things bother you? _____

_____ _____

71. Is the brightness of your teeth important to you? [Y] [N]

72. If you could change anything about your smile which of the following would 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 do you see your overall oral health and/or your smile in the next 5 to 10 years?

74. **Please circle the following which are important to you when making your dental health decision.**

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology

Patient Signature: _____ **Date:** _____

Notic f Privacy Practices Acknowle ement

Kevin M. Bogdon DDS
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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