Bozart Family Dentistry

Gentle Compassionate Understanding

Albert T. Bozart, D.D.S.

Date_____ Appointment Date_____ Time_____

PATIENT INFORMATION:

Name_____Birthdate_____SS#_____

Address_____City_____State_____Zip_____

Sex ☐M ☐F ☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced

☐Partnered for _____years

Student Status ☐Full-time ☐Part-time School Attending_____

Home Phone # (_____)_____ Work Phone # (_____)_____ Cell # (_____)_____

Email Address_____

Employer _____Job Title_____

Spouse or Parent's Name_____Employer_____

Name of other family members that are patients_____

Whom may we thank for referring you?_____

Emergency contact person_____Relationship_____Phone_____

RESPONSIBLE PARTY:

Person Responsible for Account_____Relationship_____

Address_____City_____State_____Zip_____

Home Phone # (_____)_____ Work Phone # (_____)_____Cell # (_____)_____

Birthdate_____ Employer: _____ Drivers License#_____

Currently a patient in our office? ☐Yes ☐No

DENTAL INSURANCE INFORMATION:

Name of Insured_____ Relationship to patient_____

Address_____City_____State_____Zip_____

Birthdate_____ SS#_____ Phone # (_____)_____

Employer_____Work # (_____)_____

Insurance Company_____Group#_____

Insurance Phone #_____

Address_____City_____State_____Zip_____

Max. Annual Benefit_____ Deductible_____ Benefit used_____ Remaining_____

SECONDARY DENTAL INSURANCE INFORMATION:

Name of Insured_____ Relationship to patient_____

Address_____City_____State_____Zip_____

Birthdate_____ SS#_____ Phone # (_____)_____

Employer_____Work # (_____)_____

Insurance Company_____Group#_____

Insurance Phone #_____

Address_____City_____State_____Zip_____

Max. Annual Benefit_____ Deductible_____ Benefit used_____ Remaining_____

WE DO NOT ACCEPT OR FILE MEDICAID, MEDICARE OR MEDICAL CLAIMS

DENTAL HISTORY:

Reason for today's visit_____ Date of last dental care_____

Previous Dentist_____ Date of last dental x-rays_____

Check (☑) if you have or have had problems with any of the following:

□ Bad Breath	□ Grinding Teeth	□ Sensitivity to hot
□ Bleeding Gums	□ Loose teeth or broken fillings	□ Sensitivity to sweet
□ Clicking or popping jaw	□ Periodontal Treatment	□ Sensitivity when biting
□ Food collecting between the teeth	□ Sensitivity to cold	□ Sore or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY:

Physician's Name _____ Date of last visit_____

Are you taking or have you recently taken any Biophosphonates (Osteoporosis Medications)? _____

Have you ever had any serious illnesses or operations? ____YES ____NO If yes, describe_____

Have you ever had a blood transfusion? ____YES ____NO If yes, give approximate dates_____

(Women) Are you pregnant? ___YES ___NO Nursing? ___YES___NO Taking birth control pills? ___YES___NO

Check (☑) if you have or have had problems with any of the following:

□ Anemia	□ Cough, Persistent	□ Hernia Repair	□ Scarlet Fever
□ Arthritis	□ Cough up Blood	□ High Blood Pressure	□ Shortness of Breath
□ Artificial Heart Valves	□ Diabetes Type I___II___	□ High cholesterol	□ Skin Rash
□ Artificial Joints, Pins, etc.	□ Epilepsy/Seizures	□ HIV/AIDS	□ Special Needs
□ Asthma	□ Fainting	□ Jaw Pain	_____
□ Back Problems	□ Glaucoma	□ Kidney Disease	□ Stroke
□ Bleeding Abnormally	□ Headaches	□ Liver Disease	□ Swelling of Feet/ankles
□ Blood Disease	□ Heart Murmur	□ Mental Health Issues	
□ Cancer	□ Heart Problems/Angina	_____	□ Thyroid Problems
□ Chemical Dependency	□ Heart Attack	□ Mitral Valve Prolapse	□ Tobacco Habit
□ Chemotherapy	□ Hemophilia	□ Pacemaker	□ Tonsillitis
□ Circulatory Problems	□ Hepatitis A	□ Radiation Treatment	□ Tuberculosis
□ Congenital Heart Lesions	□ Hepatitis B	□ Respiratory Disease	□ Ulcer
□ Cortisone Treatments	□ Hepatitis C	□ Rheumatic Fever	□ Venereal Disease

Do you require premedication before dental appointments? ___YES___NO

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies:

□ Aspirin	□ Local Anesthetic	□ Iodine	□ Other_____
□ Barbiturates (Sleeping Pills)	□ Penicillin	□ Latex	_____
	□ Sulfa	□ Nickel	
□ Codeine		□ None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever has a change in health. I also authorize the release of pertinent information to those persons requiring it for the treatment of myself or minor child or for the purpose of payment of the account or credit reference. I authorize payment of insurance benefits directly to Bozart Family Dentistry I understand that my dental insurance carrier may pay less than the actual bill for services and I am financially responsible for payment of services not paid, in whole or in part, by my dental insurance carrier.

_____ _____

(Name of Patient) (Relationship to Patient)

_____ _____

(Signature of Patient, Parent, Guardian or Personal Representative) (Date)

Bozart Family Dentistry

Summary Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date: October 29, 2015

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI.

Uses and Disclosures of Protected Health Information
We may use or disclose (share) your PHI to:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies
- Provide healthcare treatment for you
- If required by law
- Public health activities
- Health oversight agencies
- Legal proceedings
- Police or other law enforcement purposes
- Coroners, funeral directors
- Medical research
- Special government purposes
- Correctional institutions
- Workers' Compensation
- Business Associates
- Health Information Exchange
- Fundraising activities
- Treatment alternatives
- Appointment reminders

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Additional Privacy Rights: You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
- ❑ Other:_____
_____

Prepared By _____

Signature _____

Date _____

6132 Carolina Beach Road Suite 6 Wilmington, NC 28412
Main 910-392-9101
Fax 910-392-9041
www.bozartfamilydentistry.com

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Bozart Family Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Oct 2014