Bohannan Dentistry
Dental Registration and History

Date: _____
SS#_____ Birth date: _____
Patient Name:

_____
Last Name

_____
First Name Middle Initial

Address _____

_____
City State Zip

E-mail _____

Sex ? M ? F Age _____

❑ Married ❑ Widowed ❑ Single
❑ Separated ❑ Divorced ❑ Minor

Patient Employer/School _____
Occupation _____
Employer/School Address _____
_____
Employer/School Phone (__) _____
Spouse's Name _____
SS# _____ Birth date _____

Spouse's Employer _____

Whom may we thank for referring you?
_____

Who is responsible for this account?
_____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? ❑ Yes ❑ No
Subscriber's Name _____
SS# _____ Birth Date_____
Relationship to Patient _____
Insurance Company
_____
Group # _____

Assignment and Release
I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
Name of Insurance Co.
Dr. Bohannan all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Bohannan may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please Print Name of Patient, Parent, Guardian or Personal Representative

_____ _____

PHONE NUMBERS

HOME _____ WORK _____ ext _____
Cell phone _____ Spouse's work _____ Best time and place to reach you?_____
IN CASE OF EMERGENCY PLEASE CONTACT (Specify someone who does not live in your household.)
Name _____ Relationship _____
Home Phone _____ Work Phone _____
Email Address _____

DENTAL HISTORY

Reason for today's visit_____
Former Dentist_____ City/State_____
Date of last dental visit _____ Date of last dental x-rays _____
Place a mark on "yes" or "no" to indicate if you have had any of the following.

Bad breathe	❑yes ❑no	Burning sensation on tongue	❑yes ❑no	Mouth breathing	❑yes ❑no
Bleeding gums	❑yes ❑no	Chew on one side of mouth	❑yes ❑no	Mouth pain, brushing	❑yes ❑no
Blisters on lips	❑yes ❑no	Tobacco use	❑yes ❑no	Orthodontics	❑yes ❑no
Dry Mouth	❑yes ❑no	Fingernail biting	❑yes ❑no	Pain around ear	❑yes ❑no
Grinding teeth	❑yes ❑no	Gums swollen or tender	❑yes ❑no	Jaw pain or tiredness	❑yes ❑no
Loose teeth	❑yes ❑no	Broken fillings	❑yes ❑no	Lip or cheek biting	❑yes ❑no

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

HEALTH HISTORY Physician's Name _____ Date of last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □Yes □No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	□ Yes □ No	Epilepsy	□Yes □No	Respiratory Disease	□Yes □No
Anemia	□ Yes □ No	Fainting or dizziness	□Yes □No	Rheumatic Fever	□Yes □No
Arthritis, Rheumatism	□Yes □No	Glaucoma	□Yes □No	Scarlet Fever	□Yes □No
Artificial Heart Valves	□Yes □No	Headaches	□Yes □No	Shortness of Breath	□Yes □No
Artificial Joints	□Yes □ No	Heart Murmur	□Yes □No	Sinus Trouble	□Yes □No
Asthma	□ Yes □No	Heart Problems	□Yes □No	Skin Rash	□Yes □No
Back Problems	□Yes □No	Hepatitis Type _____	□Yes □No	Special Diet	□Yes □No
Bleeding abnormally, with extractions or surgery	□Yes □No	High Blood Pressure	□Yes □No	Swollen Feet or Ankles	□Yes □No
Blood Disease	□Yes □No	Jaundice	□Yes □No	Swollen Neck Glands	□Yes □No
Cancer	□Yes □No	Jaw Pain	□Yes □No	Thyroid Problems	□Yes □No
Chemical Dependency	□Yes □No	Kidney Disease	□Yes □No	Tonsillitis	□Yes □No
Chemotherapy	□Yes □No	Liver Disease	□Yes □No	Tuberculosis	□Yes □No
Circulatory Problems	□Yes □No	Low Blood Pressure	□Yes □No	Tumor or growth on head or neck	□Yes □No
Congenital Heart Lesions	□Yes □No	Mitral Valve Prolapse	□Yes □No		
Cortisone Treatment	□Yes □ No	Nervous Problems	□Yes □No	Ulcers	□Yes □No
Cough, persistent	□Yes □No	Pacemaker	□Yes □No	Venereal Disease	□Yes □No
Diabetes	□Yes □No	Psychiatric Care	□Yes □No	Weight Loss, unexplained	□Yes □No
Emphysema	□Yes □No	Radiation Treatment	□Yes □No		

Do you wear contact lenses? □Yes □No

Women:

Are you pregnant? □Yes □No Due date _____ Are you nursing? □Yes □No

Taking birth control pills? □Yes □No

MEDICATIONS:

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

_____

_____

_____

Do you take any herbal supplements? □Yes □No

If yes, please list: _____

_____

_____

Pharmacy Name: _____

Phone: _____

ALLERGIES:

□ Aspirin □ Local Anesthetic

□ Barbiturates (sleeping pills)

□ Codeine □ Penicillin

□ Iodine □ Sulfa

□ Latex □ Other _____

_____

Health Information Privacy
(HIPAA)

Name: _____ Date: _____

May we leave a message at home? Yes/No home number: _____

May we leave a message on your mobile? Yes/No mobile number: _____

May we leave a message at work? Yes/No work number: _____

Please list all persons to whom we may talk concerning your dental care:

1. _____

2. _____

3. _____

4. _____

Signature: _____

Bohannan Dentistry
8237 MID CITIES BLVD | NORTH RICHLAND HILLS TX, 76182 | (817) 485-1144

Written Financial Policy

Thank you for choosing Bohannan Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express, or Discover Card

  We offer a 10% courtesy accounting adjustment to patients who don't have insurance and pay for their treatment with cash or check prior to completion of care.

- Convenient Monthly Payment Options from CareCredit Healthcare Credit Card, subject to credit approval.
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Bohannan Dentistry requires payment prior to the completion of your treatment. (If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.) For plans requiring more than 2 appointments, we may allow you to pay half when we start treatment and the remaining balance will need to be paid when treatment is completed.

Patients who carry any form of insurance should know that all services furnished are provided directly to the patient and that he or she is ultimately responsible for payment. We will help prepare your primary forms to assist in the making of collections from your insurance company and will credit such collections to your account. However, we do not render services based on the assumption that all of our charges will be paid by your insurance company. Your bill with us ultimately is **YOUR** responsibility, even if you believe that it should be covered by insurance. Serious insurance payment problems are uncommon, but most misunderstandings about what insurance does and **does not** cover can be avoided if you understand exactly what coverage your policy provides.

We will also try to assist you with any necessary "pre-authorization" for your dental procedures at your request, but it is ultimately your responsibility to be sure that all pre-authorization criteria required by your insurance are met. Also, please note that **NO** insurance company guarantees payment based on their giving pre-authorization. They may later decide to deny payment for part or all of our charges leaving **YOU** responsible for payment. It is in your own best interest to personally contact your insurance company to be sure that all of the requirements for payment have been met (e.g. premiums have been paid, pre-authorization was obtained, no "pre-existing" condition was present that would cause them to deny payment, etc.)

A fee of $35 is charged for patients who miss or cancel without 24-hour notice.

Bohannan Dentistry charges $30 for returned checks and any fees that may accrue from any banking institutions.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Bohannan Dentistry

8237 Mid Cities Blvd
North Richland Hill, TX 76182
817-485-1144
Website: www.bohannandentistry.com
Email: info@bohannandentistrv.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Instruction C: Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."

Instruction D: The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.

Instruction E: If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.

To leave this section blank, add a word space to delete the instructions.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective date: 02/06/2019

This Notice of Privacy Practices applies to the following organizations.

Instruction H: Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. In addition to the copy we will provide you, copies of the current notice are available by accessing our website at www.bohannandentistry.com.

Please sign this form to acknowledge receipt of the Notice of Privacy Practices. You may refuse to sign this acknowledgement, if you wish.

Acknowledgement:

I acknowledge that I have receive a copy of the Notice of Privacy Practices.

_____

(Name of Patient)

_____ _____

(Signature of Patient or Patient's Representative) *(Date)*

_____

(Relationship to Patient)

For Office Use Only:

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices from the individual noted above, but it could not be obtained because:

- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ A communication barrier prevented us from obtaining acknowledgement
- ☐ The individual was unwilling to sign
- ☐ Other:

_____

_____

STAFF MEMBER SIGNATURE: _____ DATE:_____