Kathryn E. Boehly, DMD

6290 Linton Boulevard, Building IV, Suite 202, Delray Beach, Florida 33484
Phone: (561) 381-4744 Fax: (561) 381-4743 reception@drboehly.com www.drkathrynboehly.com

PATIENT ACQUAINTANCE FORM

Patient Name (First, Middle, Last): _____

Address: _____

City: _____ State: _____ Zip Code: _____ Single: ☐ Married: ☐ Widowed: ☐ Divorced: ☐

Home Phone: (_____) _____-_____ Cellular Phone: (_____) _____-_____ Business Phone: (_____) _____-_____

Email Address: _____@_____ Birth Date: _____/_____/_____

I would like to receive email reminders ☐Y ☐N I would like to receive text message reminders ☐Y ☐N

Social Security Number: _____-_____-_____ Person Responsible for My Account: _____

Employer: _____ Occupation: _____

I was referred to this office by:

☐ Patient: _____ ☐ Physician _____ ☐ Online _____

☐ Postcard/Mailer ☐ Magazine Ad ☐ Yellow Pages Book ☐ Other _____

Dental Insurance Company: _____ Phone Number: (_____) _____-_____

Please fill in the following if primary member is different than patient,

Insured's Name: _____ Insured's Birth Date: _____/_____/_____

Insured's Social Security Number: _____-_____-_____ Relationship to Insured: ☐ Spouse ☐ Child ☐Other

Insured's Employer: _____

Our office is dedicated to the concept that all people should have the right to retain their natural teeth for a lifetime. Preventative measures, high quality care, and good cooperation combined with timely treatment, make it possible for most people to retain their natural teeth with optimum comfort, function, and appearance. My staff and I are dedicated to this concept and with your cooperation we will do everything we can to help you reach your goals for dental health.

*****I acknowledge that I received a copy of Dr. Boehly's & Associates Notice of Privacy Practices (HIPPA)*****
***** I acknowledge that the Financial Responsibility Agreement has been read in its entirety. I also understand that payment of this account is my full responsibility*****

Print Patient Name:_____Patietn/Guardian Signature:_____Date:_____

PATIENT HEALTH HISTORY FORM

Pharmacy Name/Phone Number/Location: _____

Medical Physician's name: _____ Phone Number: (____) _____ - _____

Date of last physical examination:_____

Are you currently under medical care? ☐**Y** ☐**N** If so, for what?: _____

Any previous surgeries, hospitalizations, or recent illness: _____

Any/All **medications**, **over-the-counter**, **supplements**, and **homeopathic remedies** taken regularly:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Any/All **allergies** or **adverse reactions** to medications, anesthesia, latex, or dental materials:

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetic ☐

Other ☐ _____

Have you ever been pre-medicated with antibiotics prior to a dental visit? ☐**Y** ☐**N** If so, why: _____

Have you ever been taken bisphoshonates? ☐**Y** ☐**N** If so, why: _____

Aids/HIV Positive	☐Y ☐N	Cortisone Medicine	☐Y ☐N	Hemophilia	☐Y ☐N	Renal Dialysis	☐Y ☐N
Alzheimer's disease	☐Y ☐N	Diabetes	☐Y ☐N	Hepatitis A	☐Y ☐N	Rheumatic Fever	☐Y ☐N
Anaphylaxis	☐Y ☐N	Drug Addiction	☐Y ☐N	Hepatitis B or C	☐Y ☐N	Rheumatism	☐Y ☐N
Anemia	☐Y ☐N	Easily Winded	☐Y ☐N	Herpes	☐Y ☐N	Scarlet Fever	☐Y ☐N
Angina	☐Y ☐N	Emphysema	☐Y ☐N	High Blood Pressure	☐Y ☐N	Shingles	☐Y ☐N
Arthritis/Gout	☐Y ☐N	Epilepsy or Seizures	☐Y ☐N	Hives or Rash	☐Y ☐N	Sickle Cell Disease	☐Y ☐N
Artificial Heart Valves	☐Y ☐N	Excessive Bleeding	☐Y ☐N	Hypoglycemia	☐Y ☐N	Sinus Trouble	☐Y ☐N
Artificial Joints	☐Y ☐N	Excessive Thirst	☐Y ☐N	Irregular Heartbeat	☐Y ☐N	Spina Bifida	☐Y ☐N
Asthma	☐Y ☐N	Fainting Spells/Dizziness	☐Y ☐N	Kidney Problems	☐Y ☐N	Stomach Disease	☐Y ☐N
Blood Disease	☐Y ☐N	Frequent Cough	☐Y ☐N	Leukemia	☐Y ☐N	Stroke	☐Y ☐N
Blood Transfusion	☐Y ☐N	Frequent Diarrhea	☐Y ☐N	Liver Disease	☐Y ☐N	Swelling of Limbs	☐Y ☐N
Breathing Problem	☐Y ☐N	Frequent Headaches	☐Y ☐N	Low Blood Pressure	☐Y ☐N	Thyroid Disease	☐Y ☐N
Bruise Easily	☐Y ☐N	Genital Herpes	☐Y ☐N	Lung Disease	☐Y ☐N	Tonsillitis	☐Y ☐N
Cancer	☐Y ☐N	Glaucoma	☐Y ☐N	Mitral Valve Prolapse	☐Y ☐N	Tuberculosis	☐Y ☐N
Chemotherapy	☐Y ☐N	Hay Fever	☐Y ☐N	Osteoporosis	☐Y ☐N	Tumors or Growths	☐Y ☐N
Chest Pains	☐Y ☐N	Heart Attack/Failure	☐Y ☐N	Parathyroid Disease	☐Y ☐N	Ulcers	☐Y ☐N
Cold Sores/Fever Blisters	☐Y ☐N	Heart Murmur	☐Y ☐N	Psychiatric Care	☐Y ☐N	Venereal Disease	☐Y ☐N
Congenital Heart Disorder	☐Y ☐N	Heart Pace Maker	☐Y ☐N	Radiation Treatments	☐Y ☐N	Yellow Jaundice	☐Y ☐N
Convulsions	☐Y ☐N	Heart Trouble/Disease	☐Y ☐N	Recent Weight Loss	☐Y ☐N	Are you pregnant	☐Y ☐N

_____

Have you ever had any serious illness not listed above? ☐Y ☐N If yes, please explain: _____

Do you use tobacco? ☐Y ☐N If yes, how much daily/weekly? _____

Do you consume Alcohol? ☐Y ☐N If yes, how much daily/weekly? _____

Do you use controlled substances? ☐Y ☐N If yes, how much daily/weekly? _____

Comments: _____

_____

PATIENT/GUARDIAN SIGNATURE: _____ TODAY"S DATE: _____

Patient Dental History Questionnaire

Date: _____ Patient's Name: _____

1. Last time you were seen by a dentist and for what: _____
2. Bad Breath Yes No
3. Bleeding Gums Yes No
4. Blisters/Ulcerations/Canker Sores/Cold Sores on lips or mouth Yes No
5. Chew on one side of the mouth Yes No
6. Jaw pain or discomfort Yes No
7. Grinding or Clenching of teeth Yes No
8. Clicking or Popping jaw Yes No
9. Smoking or Chewing Tobacco Yes No
10. Dry or Burning mouth Yes No
11. Mouth breathing Yes No
12. Fingernail biting Yes No
13. Food collection between the teeth Yes No
14. Gums swollen or tender Yes No
15. Sensitivity to cold, hot, sweets, biting Yes No
16. Loose teeth or broken fillings Yes No
17. History of orthodontic treatment Yes No
18. History of root canal treatment Yes No
19. History of periodontal treatment Yes No
20. How often do you brush? Not every day Once daily Twice daily 3+ Daily
21. How often do you floss? Not every week Once weekly 2-4 times weekly Everyday
22. Are you happy with your smile Yes No
23. Is there anything you would like to change about your smile Yes No
    If yes, what: _____
24. I think my mouth is: Very Healthy, Moderately Healthy, or Unhealthy.
25. It is: Very Important, Moderately Important, or Not Important for me to keep my natural teeth.
26. I think the appearance of my smile is: Excellent, Good, Fair or Poor.

Patient Signature: _____

Patient Authority to Release Dental Records

Date: _____

I (patient's name) _____ consent to the release of my dental records and radiographs including all related clinical notes, periodontal and tooth charting, progress notes, treatment plans and correspondence from any other dental professional by

(Previous dentist): _____

At the address of:

street/po box: _____

city/state/zip: _____

phone: _____

fax: _____

Website:_____

*email:_____

I hereby authorize that my records be released to: **Kathryn E. Boehly, DMD**

At the following address:

street/po box:	**6290 Linton Blvd, Suite #202**
city/state/zip:	**Delray Beach, FL 33484**
phone:	**561-381-4744**
fax:	**561-381-4743**
email:	**reception@drboehly.com**

Patient's Full Name: _____

Patient's Date of Birth: _____

Patient or Guardian's Signature: _____

Consent for Photos

Date: _____

I, _____, give Dr. Kathryn Boehly permission to use before and after photographs of my dental case for clinical and possible promotional purposes. (Please check one below.)

_____ Authorize use of my teeth and face.

_____ Authorize use of my "teeth only".

_____ I do NOT authorize any use of my photos.

Signature of Patient or Consenting Adult: _____

FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care and successful treatment. Just as we want to have clear communication and complete understanding of any dental treatment, we want the same clarity regarding finances. Please read and sign the following statement of financial policy. Please feel free to ask if you should have any questions regarding this policy.

Payment: Payment is due at the time services are rendered unless prior financial arrangements and payment plans have been made. We offer the following options as a method of payment.
1. We accept Cash, Checks, Discover Visa or MasterCard and American Express credit cards.
2. Citi-Health Card, Chase Health, and Care Credit™ Financing

Deposit for Appointments: Please understand that when you make an appointment in this office, that time is specifically reserved for you. We rarely double books appointments in order to provide you with optimal care. Therefore, payment in full or at least a 50% deposit is required to reserve time in our provider's schedule. The deposit is due at the time the appointment is scheduled. Deposits will not be required for regular "check-ups" with our hygienist

Missed Appointments/Cancellations: Our office strives to provide the highest level of patient care. As part of that care, your appointment time is reserved specifically for you. In order to continue to provide excellent service to our patients, it is important for you to commit to your scheduled appointment time. If you find that you cannot make a scheduled appointment, the office requires 48 business hours' notice so that another patient may benefit of this valuable time.

Minors: Payment for services for the treatment of minors can be made by Cash, Check, any major credit card accepted at our office or Third Party Financing, and is the responsibility of the adult accompanying the minor. Divorce: We look to the adult who has brought the child in for the appointment to be responsible for payment of services, which are rendered to the child.

Service Charges: The policy of this office is to charge 1.5% (one and 1/2 percent), which will be applied to all accounts over 30 (thirty) days late. We will charge $25 (twenty five dollars) for any returned checks.

Collections: In the event that we need to make use of an attorney or collections agency, all pertinent information will be sent to that service. Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Patient's Full Name: _____

Patient's Date of Birth: _____

Patient or Guardian's Signature: _____

Kathryn E. Boehly, DMD
6290 Linton Boulevard, Suite 202, Delray Beach, Florida 33484 Phone: (561) 381-4744 Fax: (561) 381-4743
reception@drboehly.com www.drkathrynboehly.com

READ ONLY

NOTICE OF PRIVACY PRACTICES FOR KATHRYN E BOEHLY, DMD

6290 Linton Boulevard, Suite 202, Delray Beach, Florida 33484 Phone: (561) 381-4744 Fax: (561) 381-4743
reception@drboehly.com www.drkathrynboehly.com www.facebook.com/DelrayDentist

---

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will always ask you for special written or verbal permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are: when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices; disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws; disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies; disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else; disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations; uses or disclosures for health related research; uses and disclosures to prevent a serious threat to health or safety; uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service; disclosures of de-identified information; disclosures relating to worker's compensation programs; disclosures of a "limited data set" for research, public health, or health care operations; incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information; Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home. We may also send email or text messages, unless otherwise notified.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to

someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can: ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice. ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice. ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice. ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice. get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice. get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

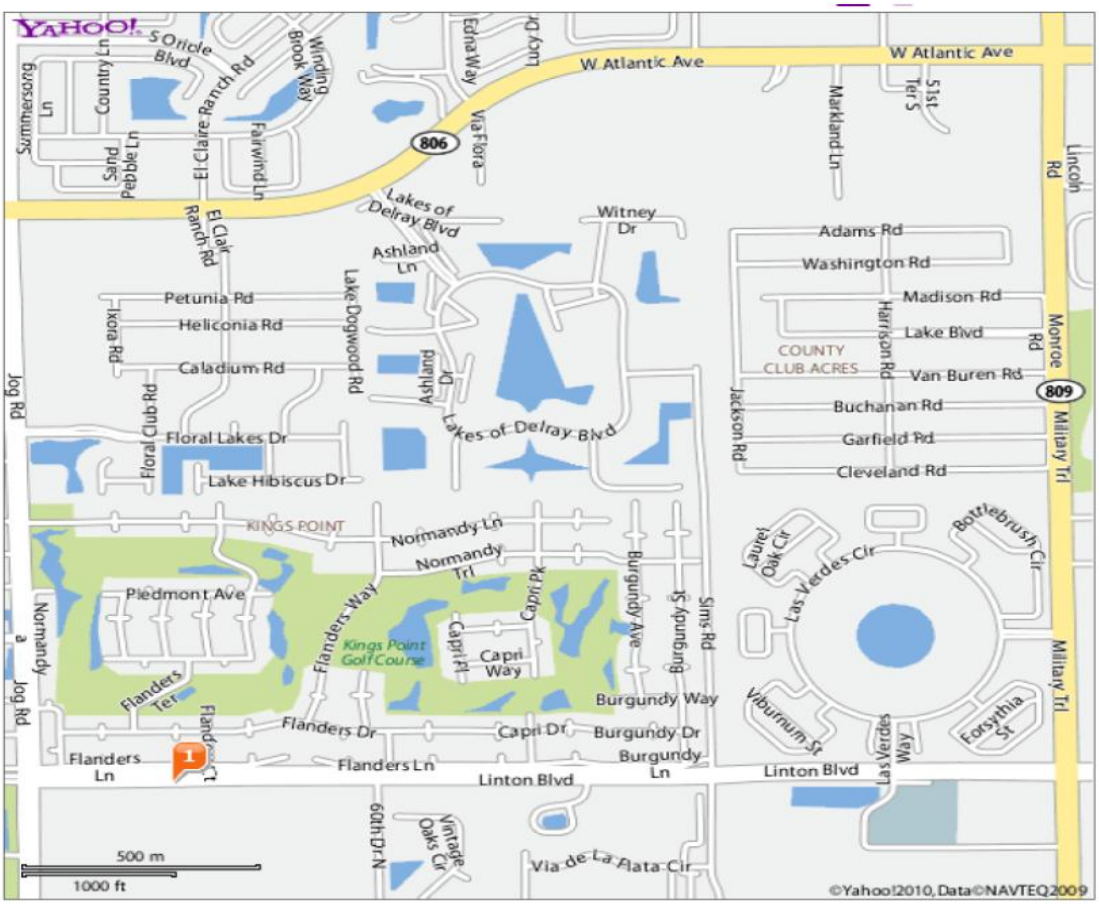
By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

Kathryn E. Boehly, DMD
6290 Linton Boulevard, Suite 202, Delray Beach, Florida 33484 Phone: (561) 381-4744 Fax: (561) 381-4743
reception@drboehly.com www.drkathrynboehly.com

OFFICE MAP



Kathryn Boehly, DMD
6290 Linton Blvd., Suite 202
Delray Beach, FL 33484

We a located just off the corner of Jog Road in The Addison Medical & Professional Complex. The Addison is located just between Drexel Park Townhomes Community and American Heritage School on the south side of Linton Boulevard. Once in The Addison Complex, we are located in the back building (number IV) and upstairs in suite #202.