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 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:_____**Patient/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: _____

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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.)

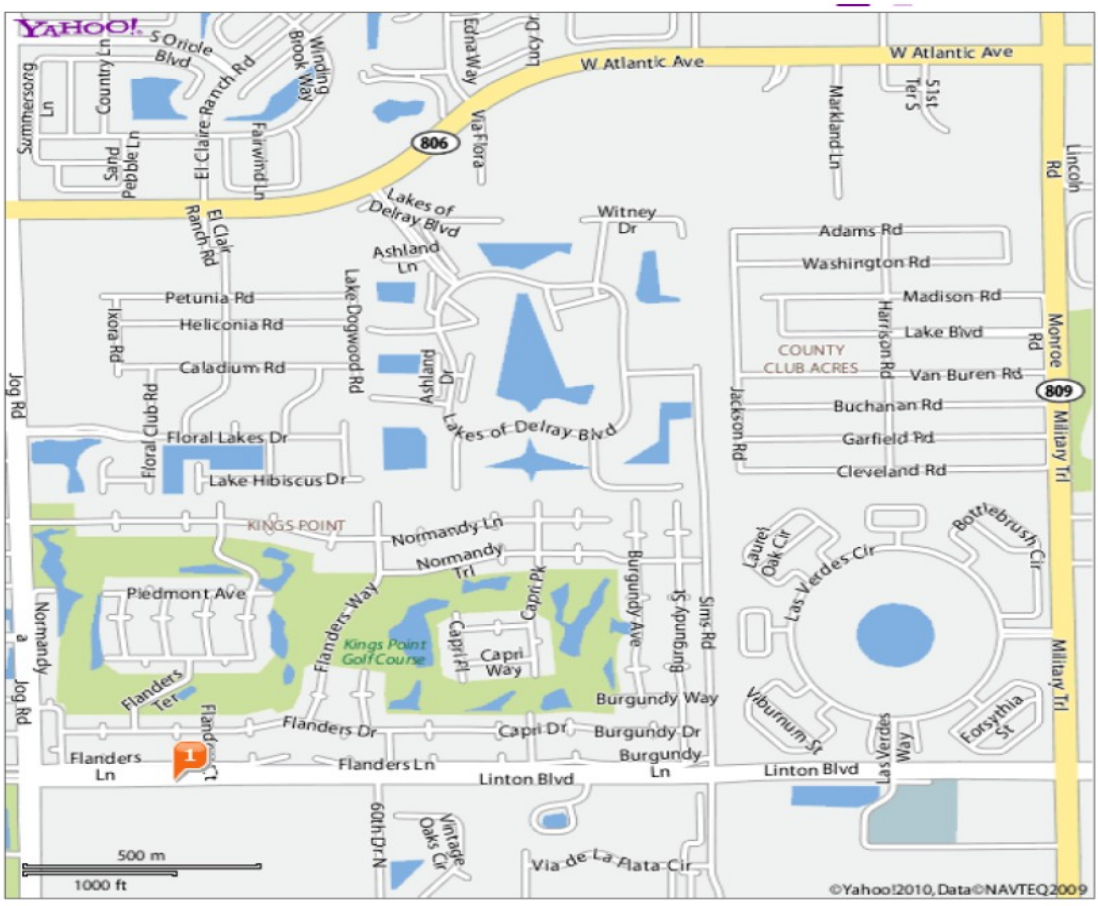
_____ Authorize use of my teeth and face.

_____ Authorize use of my "teeth only".

_____ I do NOT authorize any use of my photos.

Signature of Patient or Consenting Adult: _____

OFFICE MAP



Your Points of Interest

1. **Boehly, Kathryn E DDS - Boehly Kathryn E DDS** Phone: (561) 381-4744
   6290 Linton Blvd, #202 Delray Beach, FL 33484

We are 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.

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: _____

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