

**Bohle Family Dentistry**  
1836 Broadway Paducah, Kentucky

**Patient Information**

First Name \_\_\_\_\_ MI \_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Sex \_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Marital Status \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_  
(May We Contact) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Cell \_\_\_\_\_  
Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

**Responsible Party Information**

First Name \_\_\_\_\_ MI \_\_\_ Last Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

**Person To Contact In Case Of Emergency** \_\_\_\_\_

Phone Number \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person?

\_\_\_\_\_

**Insurance Information**

Employee's First Name \_\_\_\_\_ MI \_\_\_ Last Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Employer Phone \_\_\_\_\_ Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

**\*\*\*If you have secondary insurance, please notify us\*\*\***

**I learned of your office by:**

- Referred By \_\_\_\_\_
- Internet-Insurance Website
- Office Website
- BellSouth Yellow Pages
- Sun Talk Connection
- Newspaper-Extra
- Sign
- Other (please specify) \_\_\_\_\_

**Additional Information**

Purpose of today's appointment \_\_\_\_\_  
Date you last saw a dentist \_\_\_\_\_ For what \_\_\_\_\_  
Date of your last physical exam \_\_\_\_\_ Medical doctor's name \_\_\_\_\_

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_

Are you on a special diet?  Yes  No \_\_\_\_\_

Do you use tobacco?  Yes  No \_\_\_\_\_

Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you  
 Pregnant/Trying to get pregnant?  Nursing?  
 Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following? ...

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

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

## FINANCIAL INFORMATION

### \*\*\*PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED\*\*\*

If you have insurance, we will gladly process your forms, but we require that you pay your deductible plus your estimated portion not covered by your insurance, when services are rendered. Statements will be sent to any person who has an unpaid balance and after 30 days a finance charge will be added to the current balance at a periodic rate of 1.5% per month equal to 18% per year. A minimum finance charge of \$2.00 will be added to any due patient balance.

In case of default of payment, patient or responsible party agrees to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. In the case of a court action, the patient or responsible party is responsible for any court cost, serving fees, or attorney fees.

I agree to pay all charges for dental services and materials not covered under my dental benefit (insurance) plan to the extent permitted under applicable law. I authorize the release of any information relating to all claims being submitted on my behalf I hereby authorize payment of dental benefits directly to Dr. Charles Bohle, Jr.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date