Dr.BoggsDentistry
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Patient Demographics

Chart #.
FOR OFFICE USE ONLY

Patient Name:
Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

Birth Date: SS #. Prev. Visit:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

Address:
City State Zip Code

Spouse Name (if married) or Parent Name (if child)

Emergency Contact Information Name / Phone:

Whom may we thank for this referral?

Has any member of your immediate family been seen at our office?
Name/Relation

James B. Boggs, D.D.S., P.A.
4283 Hickory Boulevard - Granite Falls, NC 28630
Ph: 828 396 6882 | Fax: 828 396 5787

Dental Insurance Authorization

As a courtesy to you, our patient, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. We will only accept this assignment of benefits AFTER you are a patient of record with us. In other words, you must pay in full when you first come to this office. We will file your insurance claim for you and you will be reimbursed directly from your insurance company.

We never know exactly what or how much your coverage will be. We estimate what we think it will be and we ask that you pay the remaining balance at the time services are rendered. Once the insurance company reimburses us, if there is still a balance, you will be billed for the remaining portion. If there is a credit, it will be placed on your account or, if you request, a check will be sent to you.

PLEASE BE AWARE: You, the patient, are responsible for your entire account balance. If for some reason your insurance company does not pay on your claim, you will be expected to pay it in full within 30 days of the date of treatment. If your insurance company becomes unduly difficult to deal with, we will ask that you proceed with whatever measures you deem appropriate to collect on your claims.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments in full on all accounts.

By signing this statement, I revoke all previous statements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

Dental Insurance Authorization

You MUST provide us with the following information in order for us to file your claim

Name of Insured:

Last First MI

Group# ID#

Insured's Birth Date:

Insured's Address:

City State Zip

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip

Insurance Company Telephone #:

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Dental History

Reason for initial visit:

Are you aware of any particular problems?

How long since your last dental visit?

Previous dentist's name:

Reason for leaving that office:

What did you like most about your last dentist?

What did you like least about your last dentist?

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Dental History

Are you interested in keeping your teeth as healthy as possible? Yes No

Have you already lost any teeth? Yes No

Do you clench or grind your teeth? Yes No

Does your jaw click or pop? Yes No

Does food get caught in your teeth? Yes No

Are any of your teeth sensitive to: Hot Cold Sweets Pressure

Do your gums bleed or hurt? Yes No

How often do you brush your teeth? 1-2 times per day 3 or more times per day 2-3 times per week

How often do you floss your teeth? 1 time per day 2- Weekly 3 times per week Rarely

Are any of your teeth loose, tipped, shifted, or chipped? Yes No

Are you interested in any additional information about the following procedures:

Whitening Invisalign (Orthodontic straightening) Other

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Medical History

Have you been under the care of a Medical Doctor or in the hospital in the past 2 years?

Yes No

Do you use tobacco products?

Yes No

WOMEN ONLY: Are you pregnant or suspect you might be pregnant?

Yes No

If Yes, when is the due date?

Are you allergic to or made sick by:

Penicillin Aspirin Codeine Sulfa Latex Other

If yes, please explain

Do you require antibiotic premedication before dental treatment?

Yes No

What antibiotic do you pre-medicate with?

Amoxicillin Clindamycin Keflex Other

Please list "other" pre-medication:

Have you ever had an allergic reaction to any anesthetic?

Yes No

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Medical History

Please list any medications or supplements you are currently using:

Are you currently taking or have you EVER taken ANY medication or injections to treat or prevent osteoporosis?

Have NEVER taken any form of bisphosphonate.
Have PREVIOUSLY taken a form of bisphosphonate.
CURRENTLY taking a bisphosphonate.

Please select the medication name:

Actonel (Risedronate)
Aredia (Pamidronate)
Boniva (Ibandronate)
Dedronel (Etidronate)
Fosamax (Alendronate)
Prolia (Demosumab)
Reclast (Zoledronic Acid)
Skelid (Tiludronate)
Zometa (Zoledronate)

Please list any other types of bisphosphonates you are taking for osteoporosis or cancer therapy.

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Medical History

Please mark any of the following to indicate YES if you had or have at present:

Acid Reflux
Alcoholism
Anxiety / Nervous
Artificial Joints
Bleeding Problems / Blood Disease
Bruise Easily
Chemotherapy
Osteoporosis
Diabetes
Emphysema
Excessive Bleeding
Fibromyalgia
Heart Attack
Heart Murmur
Hepatitis
Hormone Replacement
Kidney Disease
Mental Illness
Pacemaker / Defibrillator
Pneumonia
Rheumatism
Steroid Therapy
Thyroid Disease

AIDS / HIV
Anemia
Artificial Heart Valve
Asthma
Blood Transfusion
Cancer
Cold / Fever Blister
Depression
Eating Disorder
Epilepsy / Seizures
Fainting / Dizzy Spells
Headaches
Heart Disease / Angina / Poor Circulation
Heart Surgery
High Blood Pressure
Immune Disease
Liver Disease
Mitral Valve Prolapse
Palpitations / Irregular Heart Beats
Radiation Treatment
STD
Stroke
Tuberculosis

List any disease, condition or problem not listed:

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Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

I have reviewed a copy of the Notice of Privacy Practices for the office of James B Boggs, D.D.S., PA

NOTE: Not all terms and conditions expressed in ident.com disclaimer apply to the web site and/or dental practice of James B Boggs, D.D.S., PA, specifically references to online credit card payment services.

By checking this box, I acknowledge that I have read and understand James B . Boggs, D.D.S., PA financial policies, and that I have given accurate medical history to the office. If my medical history changes, I will inform the office about those changes.

Relationship to patient:

Response Date:

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Medical Information Release

Patient Name:

James B. Boggs, DDS is authorized to release protected health information of the above listed patient to entities listed below. Please list the name(s) of person(s) and relation to whom your dental information and/or treatment can be released:

Spouse is approved to receive the following information:

Results of lab tests / x-rays
Completed Dental Treatment / Condition
Financial
All Future Dental Treatment / Condition

Parent(s) - (Does not apply if patient is under 18 yrs of age) is approved to receive the following information:

Results of lab tests / x-rays
Completed Dental Treatment / Condition
Financial
All Future Dental Treatment / Condition

Grandparent(s) is approved to receive the following information:

Results of lab tests / x-rays
Completed Dental Treatment / Condition
Financial
All Future Dental Treatment / Condition

Other (as listed above) is approved to receive the following information:

Results of lab tests / x-rays
Completed Dental Treatment / Condition
Financial
All Future Dental Treatment / Condition

Authorization

Appointment Date and Time information is NOT protected health information. Our office staff will be calling to request reconfirmation for all appointments in order to reserve the time we have scheduled for you. If confirmation is not received 48 hours prior to the appointment time you may be asked to reschedule your appointment.

Staff of James B Boggs, DDS, PA are allowed to leave the following information on a voice mail or answering machine:

Results of lab test / x-rays

Dental Insurance Coverage Information / Verification

None - Leave Message to Request Patient / Patient's Parent or Legal Guardian to Call the Office.

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be condition on signing.

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL REVOKED BY THE PATIENT.

Acknowledgement: Yes No

I have read and received a copy of the Notice of Privacy statement for the office of James B. Boggs DDS, PA. Yes No

Response Date