

*Kathryn E. Boehly, DMD & Associates*

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

**Acquaintance Form**

Today's Date: \_\_\_\_\_

Patient Name (First, Middle, Last): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Single: \_\_\_\_\_ Married: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Person Responsible for My Account: \_\_\_\_\_

I was referred to this office by: \_\_\_\_\_

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: \_\_\_\_\_

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.*

**Kathryn E. Boehly, DMD & Associates**  
**Health History**

Pharmacy Name/Phone Number/Location: \_\_\_\_\_

Medical Physician's name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Are you currently under medical care? **YES NO** If so, for what?: \_\_\_\_\_

Any/All 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: \_\_\_\_\_

Have you ever been pre-medicated with antibiotics prior to a dental visit? **YES NO** If so, why?: \_\_\_\_\_

**Do you have a history of any of the following?:**

**Comments**

Arthritis	Yes No	_____
Artificial joints	Yes No	_____
Artificial heart valves	Yes No	_____
Mental Disorders	Yes No	_____
High/Low Blood Pressure	Yes No	_____
Osteoporosis	Yes No	_____
Asthma	Yes No	_____
Diabetes	Yes No	_____
Liver problems	Yes No	_____
Hepatitis	Yes No	_____
Kidney problems	Yes No	_____
Epilepsy	Yes No	_____
Lupus	Yes No	_____
HIV disease/AIDS	Yes No	_____
Prolonged Bleeding	Yes No	_____
Bruise easily	Yes No	_____
Swelling of extremities	Yes No	_____
Cancer	Yes No	_____
Smoker/Chewing Tobacco	Yes No	_____
Alcohol Consumption	Yes No	_____
Headaches	Yes No	_____
Glaucoma vision problems	Yes No	_____
Vertigo	Yes No	_____
TB	Yes No	_____

**Patient Signature:** \_\_\_\_\_ **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: \_\_\_\_\_

# ViziLite Plus Oral Cancer Screening Acceptance Form

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

***One person dies every hour from oral cancer in the United States.***

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, 25% of oral cancer victims have no lifestyle risk factors.

## Oral Cancer Risk Profile

### Increased Risk

- ~ Patients age 40 and older (95% of all cases)
- ~ 18-39 years of age combined with any of the following:
  - Tobacco use
  - Chronic alcohol consumption
  - Oral HPV infection

### Highest Risk

- ~ Patients age 65 and older with lifestyle risk factors
- ~ Patients with history of oral cancer

25% of oral cancers occur in people who don't smoke and have no other risk factors.

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better change to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file procedure with your medical insurance. The fee for this enhanced examination is \$65.00.

**PLEASE CIRCLE ONE OF THE FOLLOWING, SIGN AND DATE AT THE BOTTOM.**

YES: I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

NO: I would prefer not to have the ViziLite Plus exam at this time.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## 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, and Visa or MasterCard 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. 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, but please see missed appointments for further information.

**Missed Appointments:** Once a dental appointment has been made, please keep in mind that this time has been reserved especially for you. We rarely double books appointments in order to provide you with optimal care; therefore it is hard for us to fill openings made at the last minute. For changes or cancellations we do require a full 48 (forty-eight) business-hour notice. We reserve the right to charge \$30 (thirty dollars) per hour for oral hygiene appointments and periodontal treatment appointments scheduled with our Hygienist when a full 48 (forty-eight) business-hour notice is not provided. There will be a charge of \$50 (fifty dollars) per hour for appointments scheduled with our Dentists that are cancelled or rescheduled without a full 48 (forty-eight) business-hour notice. Please understand that messages left on voice-mail for appointment changes or cancellations will not be accepted and you will need to speak with a staff member during regular business hours. If you miss two or more appointments, we will ask you to prepay in full for your appointment time, which will be non-refundable if the appointment is missed.

**Minors:** Payment for services for the treatment of minors can be made by Cash, Check, any major credit card accepted at our office or Care Credit™, 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. We also expect parents to be able to work our payment arrangements with each other and not to involve our office staff in any disputes that may arise.

**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.

**Dental Benefits:** We will gladly process your insurance claims. Please note that your insurance policy is a contract between you and your insurance company and as a provider, we are not party to that agreement. The quality of insurance policies varies greatly; therefore we cannot estimate or guarantee your coverage due to the complexities of dental insurance contracts. By law, insurance companies must notify you in writing or pay the claim within 30 (thirty) days. We will file insurance forms and follow up with them at no charge to you, so we can do all we can to assure you a maximum benefits.

*Facts you should know about dental insurance:* Dental insurance has played a role in helping people obtain better care. Since we strongly feel that our patients deserve the best possible treatment we can provide, and in an effort to maintain the highest quality of care, we would like to share some facts about dental insurance with you.

- ~ Dental insurance companies do not intend for their plans to cover all expenses. Their plans serve only as an aid toward acquiring better care.
- ~ Many dental plans tell their insured that they will be covered "up to 80% or 100%." In spite of what you are told, most dentists find that the majority of plans cover about 30% to 40% of an average fee. Some plans may pay more and some pay less. The amount your plan pays is determined by how much you or your employer paid for the plan. The less that is paid for the insurance, the less you benefit.
- ~ Many dental services are covered a specific number of times in a calendar year (for example, hygiene appointments may be covered only once every six months.)
- ~ Some insurance companies tell their clients that "fees are above the usual and customary fees" rather than saying to them that "our benefits are too low." In our office, we do not view our patients as "usual and customary", but as quality patients, who expect quality dentistry. Remember, your insurance benefit is limited by what you or your employer pays for the plan less profits of the insurance company.
- ~ If you have any questions regarding your insurance, we ask that you contact your employer or insurance carrier regarding the specifics and details of the plan it is conducting on your behalf.

Financial Consent: \*\*\* By signing this notice, I am acknowledging that the policy has been read in its entirety. I also understand that payment of this account is my full responsibility.\*\*\*

Patient Name: \_\_\_\_\_

Patient/Consenting Adult Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **NOTICE OF PRIVACY PRACTICES FOR KATHRYN E BOEHLY, DMD & ASSOCIATES**

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

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**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.**

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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.

**\*\*\*I acknowledge that I received a copy of Dr. Boehly's Notice of Privacy Practices\*\*\***

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# 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, 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: \_\_\_\_\_

I hereby authorize that my records be released to:

**Kathryn E. Boehly, DMD & Associates**

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: \_\_\_\_\_

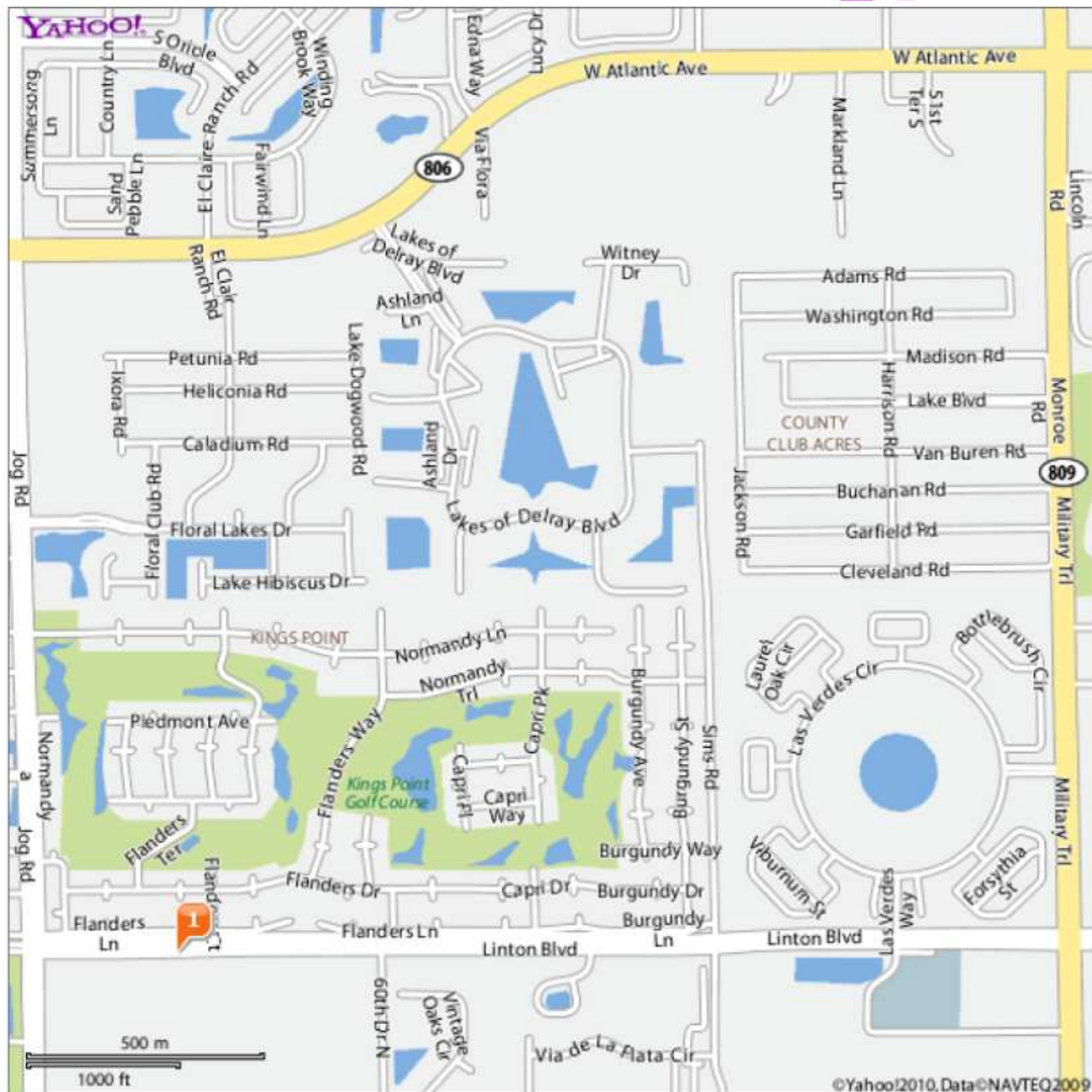
Patient's Date of Birth: \_\_\_\_\_

Patient or Guardian's Signature: \_\_\_\_\_

*Kathryn E. Boehly*, DMD & ASSOCIATES

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## 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 Town Homes 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\*\*\*