



## *Bozart Family Dentistry*

*Gentle Compassionate Understanding  
Albert T. Bozart, D.D.S.*

### *Notice of Privacy Practices*

*The Health Insurance Portability and Accountability Act (HIPAA) requires our office to advise you of your rights and our responsibility regarding this new law pertaining to your records and health information.*

*Here is our "short and sweet" version for your reading pleasure:*

*This law requires us to maintain the privacy of your records. If the law changes in any way, you will be notified.*

*Your records will be used only for Treatment, Payment and Health Care Operations purposes.*

*We may disclose your information directly to you upon request, in any emergency situation, and with your authorization. Disclosure may be given to other professionals regarding your dental treatment, unless you decide otherwise.*

*We are permitted to call you and leave messages to make and confirm appointments.*

*We plan to continue to respect your privacy. Should you have a complaint about a perceived breach of this law, please feel free to let us know. You can do that verbally or in writing.*

*A written copy of our Notice of Privacy Practices is available upon request.*



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## ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PATIENT PRIVACY NOTICE

I have received a copy of Bozart Family Dentistry's Patient Privacy Notice.

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

Parent/Guardian Name: \_\_\_\_\_

I, \_\_\_\_\_, authorize the following individuals to have access to and be informed of the above named patient's dental/medical information and dental/medical care.

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other \_\_\_\_\_

6132 Carolina Beach Road Suite 6  
Wilmington, NC 28412

Main 910-392-9101  
Fax 910-392-9041

[www.wilmington-dentist.com](http://www.wilmington-dentist.com)

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

ARE YOU REQUIRED TO TAKE PREMEDS BEFORE DENTAL APPTS? \_\_\_\_ Yes \_\_\_\_ No

Check (✓) if you have or have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad Breath                        | <input type="checkbox"/> Grinding Teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding Gums                     | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw           | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collecting between the teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Have you ever had any serious illnesses or operations??  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have had problems with any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Congenital Heart lesions | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism         | <input type="checkbox"/> Cortisone Treatments     | <input type="checkbox"/> Hernia Repair         | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves       | <input type="checkbox"/> Cough, Persistent        | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Cough up Blood           | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems                 | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Bleeding Abnormally           | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Blood Disease                 | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemical Dependency           | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Chemotherapy                  | <input type="checkbox"/> Heart Problems           | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Circulatory Problems          | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Rheumatic fever       | <input type="checkbox"/> High cholesterol           |

List medications you are currently taking: \_\_\_\_\_ Do you require premedication before dental appointments?  Yes  No

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies:

- |  |   |                                 |                                      |
|--|---|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin       | <input type="checkbox"/> Latex  | _____                                |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            | <input type="checkbox"/> None   |                                      |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
 Signature of of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Please print name of Patient

\_\_\_\_\_  
 Relationship to Patient

Bozart Family Dentistry  
6132 Carolina Beach Rd Ste 6  
Wilmington, NC 28412  
(910) 392-9101

WE ARE HAPPY TO FILE YOUR DENTAL CLAIMS AS A  
COURTESY TO YOU, BUT WE MUST HAVE THE  
INSURED'S SS# & DOB

ATTENTION:  
WE DO NOT ACCEPT OR FILE MEDICAID, MEDICARE  
OR MEDICAL CLAIMS

Date \_\_\_\_\_

### PATIENT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Home Phone # ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Job Title \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Names of other family members that are patients \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Emergency contact person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### RESPONSIBLE PARTY

Name of Person \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Responsible for this Account \_\_\_\_\_

Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Birthdate \_\_\_\_\_ Currently a patient in our office?  Yes  No

Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Drivers License # \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Insurance phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

### SECONDARY DENTAL INSURANCE

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Insurance Phone# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_