Tammy M. Boudry, DDS
Boudry Dental LLC

Patient Information

Record# (office use):_____ Relation: Self Spouse Child Other
Responsible Party Name(person to bill):_____
Patient Name:_____
First Middle Last
Preferred Name (nick name): _____
Address:_____
City:_____ **State:**_____ **Zip:**_____
Home Phone:_____ **Work Phone:** _____
Mobile Phone: _____ **Fax:** _____
Email Address: _____
Birthdate: _____ **Social Security Number:** _____
Gender: Male Female **Marital Status**: Single Married Other
Who can we thank for this referral? _____

****

Insurance Information

This office will be happy to assist in every way we can with the processing of insurance claims and estimates. **Patients are responsible for charges not covered by their insurances**. Please be aware of your deductibles, percentage co-pay, dates of coverage, etc.

Primary:
Relation to Insured: Self Spouse Child Other **Subscriber Name**:_____
Subscriber Date of Birth:_____ **Subscriber S. S.#:** _____
Insurance ID Number: _____ **Group Number:** _____
Insurance Carrier: _____
Name Address
Employer:_____ **School Name** (if student):_____

Secondary: (if applicable)
Relation to Insured: Self Spouse Child Other **Subscriber Name**: _____
Subscriber Date of Birth: _____ **Subscriber S.S. #:**_____
Insurance ID Number: _____ **Group Number:** _____
Insurance Carrier:_____
Name Address
Employer:_____ **School Name** (if student): _____

X Signature: _____ ***Date:*** _____

Medical Information

1. Do you have any Allergies? If yes, please specify. **Yes** **No**

   _____

   _____

2. Are you currently taking any medications? If yes, please specify. **Yes** **No**

   _____

   _____

3. Have you ever had any Major Surgery? If yes, please specify type(s). **Yes** **No**

   _____

   Approximate Date(s) _____

4. Do you have Artificial Hips, Knees, or any other joints? **Yes** **No**
5. Have you been told you needed a PRE-MED? If yes, please specify. **Yes** **No**

   _____

   Approximate Date of Surgery:_____
6. Have you ever taken any medication to treat obesity, bone disease, or stroke? **Yes** **No**
7. Are you on a special diet? **Yes** **No**
8. Are you pregnant? **Yes** **No** **8.** Taking oral Contraceptives **Yes** **No**

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

__AIDS/HIV Positive
__Alzheimer's Disease
__Anaphylaxis
__Anemia
__Angina
__Arthritis
__Artificial Heart Valve
__Asthma
__Blood Disease
__Blood Transfusion
__Breathing Problem Hay Fever
__Bruise Easily
__Cancer
__Chemotherapy
__Cold Sores/Fever Blisters
__Convulsions
__Congenital Heart Disorder
__Cortisone Medicine
__Diabetes
__Drug Addiction
__Easily Winded
__Excessive Thirst
__Excessive Bleeding
__Emphysema
__Epilepsy or Seizures
__Fainting/Dizziness
__Frequent Cough
__ Frequent Diarrhea
__ Frequent Headaches
__ Genital Herpes
__ Glaucoma
__ Gout/ Chest Pains
__Heart Attack/Failure
__Heart Murmur
__Heart Trouble/Disease
__Hemophilia
__Hepatitis A,B,C
__Herpes
__High Blood Pressure
__Hives or Rash
__Hypoglycemia
__Irregular Heartbeat
__Jaw pain
__ Kidney Problems
__Leukemia
__Liver Disease
__Low Blood Pressure
__Lung Disease
__Mitral Valve Prolapse
__Osteoporosis/Bone Disease
__Parathyroid Disease
__Psychiatric Care
__Radiation Treatments
__Recent weight loss
__Renal Dialysis
__Rheumatoid Arthritis
__Rheumatic Fever
__Shingles
__Sickle Cell Disease
__Sinus Trouble
__ Spina Bifida
__Stomach Disease
__Stroke
__Swelling Limbs
__Tonsillitis
__Thyroid Disease
__Tuberculosis
__Tumors
__Yellow Jaundice

Other Please Explain:_____

_____

Name and phone number of your physician: _____

Name and Number to call in the event of an emergency: _____

Signature: _____ ***Date:*** _____

Tammy M. Boudry, D.D.S.
Boudry Dental LLC

Name: _____ **Birth Date**_____
First Middle Last

Dental Information

1. When was your last dental visit? _____
2. When were your last dental x-rays taken? _____
3. Do you have any areas of concern or sensitivity? If yes, please explain.
   _____
4. Have you had past orthodontic treatment? **Yes** **No**
5. Have you had your wisdom teeth removed? **Yes** **No**
6. Do you have reoccurring canker sores or cold sores? **Yes** **No**
7. Do you have lumps or sores (lesions) in your mouth now? **Yes** **No**
8. Have you ever been treated for gum or periodontal disease? **Yes** **No**
9. Do you experience dry mouth? **Yes** **No**
10. Do your teeth feel sore when you bite on them? **Yes** **No**
11. Do you clench or grind your teeth? **Yes** **No**
12. Does your jaw click or pop? **Yes** **No**
13. Are you unhappy with the appearance of your teeth? **Yes** **No**
14. Are you interested in whitening? **Yes** **No**
15. Do hot, cold or sweet beverages cause discomfort/pain in your mouth? **Yes** **No**
16. What are your feelings regarding fluoride? _____

SIGNATURE: _____ **DATE:** _____

Tammy M. Boudry D.D.S
Wisconsin Consent

Purpose: This form is to obtain an individual's written permission under Wisconsin Law for our use and disclosure of the patient's dental care records to carry out treatment, payment activities, and health care operations.

Section A: ***Individual giving consent*** **– PLEASE COMPLETE**

Patient/Legal Guardian Name: _____

Address: _____

Patient name: _____ Date of Birth: _____

Is there any other person with whom we may discuss your dental health?

_____ _____

_____

{Persons Name} **{Relationship}** **{Phone Number}**

TO THE INDIVIDUAL: Please read the following and complete the information requested

Privacy Practices notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides description of our treatment, payment activities, and health care operations, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of your Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes.

SECTION B: ***The uses and disclosures being authorized.***
Our Use of Dental Health Information: by signing this form you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Signing This Consent Is Not Limited to, but Does Allow us to:

*Send you appointment reminder post cards, emails or texts/calls
*Leave voice mail or recorded messages regarding appointments and or balances
*Leave voice mail or recorded messages regarding the need for pre-medication or medication required
*Communicate by phone, text/calls, email, fax or in writing with your insurance company.
*Communicate by phone, email, fax, or in writing with specialist involved with your care.
*Communicate dental concerns and information with responsible family member, spouse or guardian
*communicate information regarding your care with pharmacies designated by you.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Signature: **Date:**

In signing this form I am confirming that all the information that I have provided on the Health History Form is true and up to date.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact Person. Please understand that revocation of this Consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Informed Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or minor patient) have a heart condition or heart murmur, advise your dentist, immediately so s/he can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally. Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip bone fragment or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery.
14. Recession or bone loss

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient Portion ↓

Office Portion ↓

_____ _____ _____

Signature Parent/Legal Guardian **Date** Witness Signature Date

Boudry Dental Financial Policy

Thank you for choosing Boudry Dental for your dental needs. We are committed to providing you with the highest quality of care. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve with respect to your budget. We are always available to answer your questions or assist you in any way we can.

Your clear understanding of our financial policy is important to our professional relationship. To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Full payment is due at the time of service for any balance under $200.00 and for all dental appliances.

Optional Payment Terms

1. **Major Service – Two payment option**: We offer a two-payment option for Crown, Bridge & Denture treatment. We ask that you pay one-half of your balance at the first appointment with the second half being due at the seat date 2-3 weeks later, or final try in for dentures.

2. **Credit Card Payment Options:** We allow (with a signed agreement form) three equal installments to be made by credit card, one-third of your balance is due at the first appointment, one-third is due thirty days later and the remaining one-third is due sixty days from the initial appointment. Our office insurance coordinator will automatically charge these payments to your credit card on the due dates, which will be the 1st business day of each month.

3. **BDM**: Pay treatment in full, the same day of service and receive a 10-20% discount

For Patients with Insurance Please Note:
Co-pay amounts are estimates based on the information we get from your insurance carrier. Any balance remaining after insurance pays will be your responsibility regardless of the difference from the estimated amount. If you require an exact co-pay amount, please let our front staff know, as a pre-estimate of benefits may be sent to your insurance carrier. It takes 3-4 weeks for the pre-estimate to return.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some of the services provided may be non-covered services or not be considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary fee for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information may be required at the time of service. You are responsible for informing us any changes in coverage. We can make no guarantee of estimated coverage for payment. Be assured we will do everything possible to help you receive the full benefits of your policy. Insurance claims cannot be back dated.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least a 24 hour notice. After the first broken appointment without a 24 hour notice any additional broken or late cancel appointments will subject to a $35.00 non-refundable cancellation fee may apply.

Unpaid Balances: Failure to comply with the above financial agreement will result in a penalty collections fee of 35% of remaining balance. If any previous discounts or adjustments were given those will be null and void.

Signature: _____ Date: _____

TAMMY M. BOUDRY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have reviewed a copy of this office's Notice of Privacy
(print guardian, or patient name if 18yrs or older)
Practices. I understand a copy is available to take home if requested.

_____
(Please Print Patient Name)

_____
(Guardian or Patient Signature)

_____
(Date)

For Office Use Only

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

☐ **Individual refused to sign**

☐ **Communications barriers prohibited obtaining the acknowledgment**

☐ **An emergency situation prevented us from obtaining acknowledgment**

☐ **Other (Please Specify)**

_____

_____