

Dawn A. Bova, DMD, MBA

Patient Registration

Patient Information

Patient's first name: _____ Middle Initial _____ Last Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security: _____ Drivers Lic: _____

Male Female Marital Status: Married Single Divorced Separated Widowed

E-mail: _____ I would like to receive correspondences via e-mail

How did you hear about our office? _____

Responsible Party (if someone other than patient)

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail

Primary Insurance Information

Name of Insured: _____ Relationship to Pt Self Spouse Parent Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Ins. Company: _____ Group Number: _____ Employer: _____

Ins. Address: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Pt Self Spouse Parent Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Ins. Company: _____ Group Number: _____ Employer: _____

Ins. Address: _____ City, State, Zip: _____

Payment Policy

We expect payment to be made at the time services are rendered. As a courtesy, we will gladly submit your insurance claim. If for any reason your insurance does not pay, you are responsible for that portion. For your convenience, we accept Visa or Master Card.

There may be a \$50.00 to \$100.00 fee for cancellation with less than 24 hours notice.

Accounts over 90 days will be charged a 1% finance charge.

Signature

Date

Dawn A. Bova, DMD, MBA
Patient Health History Questionnaire

Patient name: _____ Date of Birth: _____

Reason for today's visit: _____

Are you allergic to any medications? Yes No Please specify: _____

Are you allergic to latex? Yes No

Have you ever had a reaction to dental anesthesia? Yes No

Please specify: _____

Please list all medications you are taking (including prescriptions, Over-the-counter, vitamins, and herbals):

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

Dental Problems

- Cold sores
- Injury to face or jaw
- TMJ syndrome
- Oral growths or sore spots
- Other: _____

Lung Problems

- Asthma
- Emphysema
- Cystic fibrosis
- Sleep apnea or severe snoring
- Other: _____

Other Medical Problems

- Eating disorder
- Blood clotting problems
- Anemia or other blood disorder
- Delayed healing
- Diabetes
- Thyroid problems
- Kidney problems
- Stomach ulcers
- Frequent or severe headaches
- Sinus trouble
- Arthritis
- Lupus, scleroderma
- Osteoporosis
- Artificial joint
- Seizure or epilepsy
- Psychiatric treatment

Cardiovascular Problems

- High blood pressure
- Stroke
- Heart attack or angina
- Heart valve problems
- Artificial heart valve
- Pacemaker
- Heart murmur
- Irregular heartbeat
- Other: _____

Infectious Problems

- Hepatitis
- HIV/AIDS/ARC
- Chronic or recurrent infection
- Other: _____

Cancer

- Type: _____
- Lymphoma / Leukemia
- Radiation / chemotherapy

Social History

Do you drink alcohol? Yes No If YES, how often _____

Do you use tobacco? Yes No If YES, what type and how often? _____

Have you ever used IV drugs? Yes No If YES, what type and how often? _____

For our female patients

Are you pregnant? Yes No Estimated Date of Delivery: _____

Are you nursing? Yes No

Please list any additional condition or concerns that Dr. Bova should be aware of: _____

SIGNATURE

DATE

Provider Signature

Date

Health history updates: _____

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Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Emergency situation
- Communication barriers Specify: _____
- Other Specify: _____

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Authorization to Leave Personal Health Information

Federal law prohibits us from giving any information regarding your health care to any third party or placing such information in a position where it might be discovered by others. This includes leaving messages with any person or on a recording device. While leaving such messages might facilitate our ability to contact you, we cannot do so without your specific consent. You may chose to withhold this consent for any reason and without any consequence.

Patient Name: _____ DOB: _____

Please check all that apply:

- May leave detailed message on voicemail at home number: _____
- May leave detailed message on voicemail at work number: _____
- May leave detailed message on cell phone number: _____
- May leave detailed message at a different location number: _____
- May leave information with spouse (name): _____
- May leave information with other family member (name): _____
- May leave information with other person (name): _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one of more of the telephone numbers listed above.

Signature of Patient

Date