Dawn Bova DMD, MBA

Please email forms back to: Office@drbova.com

Patient Information

Patient Name: ____ Date:______________
Last First MI

☐ Male ☐ Female ☐ non-Binary ☐ Married ☐ Single ☐ Child ☐ Other____________

Preferred Name:____________________ Email: ________________________________

SS#/SIN: ________________________________ Birth Date: ___________________________

Phone (Home): ______________ (Work): ______________(Cell):__________________________

Address: ____
Street Apartment #

____
City State/Province Zip/Postal Code

Health Information

Date of Last Dental Visit: _______________ Reason for this visit:_____________________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ ________________
☐ ________________

Medication: ____

____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- Name of Physician: ____________________________________ Phone:________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date:________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other________________

Name of person or office referring you to our practice:____

Spuse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female

Relation to Patient: ______________________________

SS#/SIN: ____________________ Birth Date: ____________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: ______________

Address: ______________________________

Street Apartment #

____

City State/Province Zip/Postal Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________________ Occupation: ______________________________

Address: ______________________________

Street City State/Province Zip/Postal Code

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________

Street City State/Province Zip/Postal Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State/Province Zip/Postal Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________

Street City State/Province Zip/Postal Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State/Province Zip/Postal Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

____

Cancellation Policy:

We charge a $75 cancellation fee for any appointments cancelled or rescheduled within a 24-hour period of appointment time.

______________________________ Date: ______________

Signature of patient, parent, or guardian

Authorization to Leave Personal Heath 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 is might be discovered by others. This includes leaving messages with any person or a recording device. While leaving such messages might facilitate our ability to contact you, we cannot do wo without your specific consent. You may choose 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 voicemail on cell phone number:__________________________________**
☐ **May leave detailed message on a different location number:_____________________________________**
☐ **May leave information with Spouse (Name):____**
☐ **May leave information with other family member (Name):_______________________________________**
☐ **May leave information with another 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. If is my responsibility to notify my healthcare provider, should I change one or more of the telephone numbers listed above.

____ Date:___________________
Signature of patient, parent, or guardian

Acknowledge 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 (HIPPA). I Understand that this information can and will be used to:

- Provide and coordinate my treatment among several health care providers who may be involved in that treatment directly and indirectly

- Obtain payment from third-party payers for health care services

- Conduct normal health care operations such as quality assessment and improvement actives

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 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.

Patients Name:_____________________________________ Date:_______________________________

Signature:____

Relationship to Patient:_______________________________

Dawn Bova D.M.D.

Family & Cosmetic Dentistry

Authorization to Release Dental Information

I authorize ______________________________________ to release information for:

Patient name: _____________________________ Date of Birth: _______________

Previous name: ____

I request and authorize the above named doctor or health care provider to transfer records and release all x-rays to:

Dawn Bova D.M.D.

7803 SE 27th St Suite 160

Mercer Island, WA 98040

(206) 230-4123

info@drbova.com

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

Signature: _____________________________________ Date: _________________