Bova DENTISTRY

DAWN BOVA DMD, MBA

PATIENT INFORMATION

Patient (Last/First/MI):

Date (MM/DD/YY):

Preferred Pronoun: ☐ Male ☐ Female ☐ non-Binary ☐ Married ☐ Single ☐ Child ☐ Other

Preferred Name:

Email:

Birth Date:

SS#/SIN:

Address (Street/Apartment/City/State or Province/Zip or Postal Code):

Phone:

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
- ☐ Hearing Loss
- ☐ 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
- ☐ Latex Allergy
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ OTHER

MEDICATION

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain:

BILLING POLICY

Our office sends electronic statements via text and email links. If you would like to opt out and prefer paper statements, please check the box below.

☐ **Opt Out of Electronic Billing**

CANCELLATION POLICY

We charge a **$75** cancellation fee for any appointment that is cancelled or rescheduled within a 24-hour business period.

Signature

Date

Bova DENTISTRY

INSURANCE INFORMATION

PRIMARY

Name of Insured (Last/First/MI):

Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: ID#:

Group#:

Insured's Address (Street/City/State or Provice/Zip or Postal Code):

Insured's Employer Name:

Address (Street/ City/State or Provice/Zip or Postal Code):

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

Insurance Plan Name and Address:

SECONDARY

Name of Insured (Last/First/MI):

Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: ID#:

Group#:

Insured's Address (Street/City/State or Provice/Zip or Postal Code):

Insured's Employer Name:

Address (Street/ City/State or Provice/Zip or Postal Code):

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

Insurance Plan Name and Address:

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 a recording device. While leaving such messages might facilitate our ability to contact you, we cannot do so without your specific consent.

You may choose to withhold this consent for any reason and without any consequence.

PLEASE CHECK ALL THAT APPLY:

☐ No Release

☐ Spouse (Name)

☐ Immediate Family (Name(s))

☐ Other (Name)

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PRIVACY POLICY

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

Bova DENTISTRY

AUTHORIZATION

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 Street 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