

# 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):

### **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 Epilepsy Kidney Disease Stomach Problems

Allergies: Excessive Bleeding Liver Disease Stroke

Fainting Mental Disorders Tuberculosis

Phone:

Glaucoma Nervous Disorders Tumors

Anemia Hearing Loss Pacemaker Ulcers

Arthritis Hay Fever Pregnancy Latex Allergy

Artificial Joints Head Injuries Due date: Codeine Allergy
Asthma Heart Disease Radiation Treatment Penicillin Allergy

Blood Disease Heart Murmur Respiratory Problems OTHER

CancerHepatitisRheumatic FeverDiabetesHigh Blood PressureRheumatismDizzinessJaundiceSinus Problems

## **MEDICATION**

Have you ever had any complications Yes following dental treatment?

If yes, please explain:

Do you have any health problems Yes that need further clarification? 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.



## **INSURANCE INFORMATION**

**PRIMARY** 

Name of Insured (Last/First/MI):

Is insured a patient? Yes No

Insured's ID#:

Birth Date:

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 Self Spouse

to insured: Other

Insurance Plan Name and Address: SECONDARY

Name of Insured (Last/First/MI):

Is insured a patient? Yes No

Insured's ID#:

Birth Date:

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 Self Spouse Child

to insured: 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.

Child

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 Other (Name) (Name(s))



## **PRIVACY POLICY**

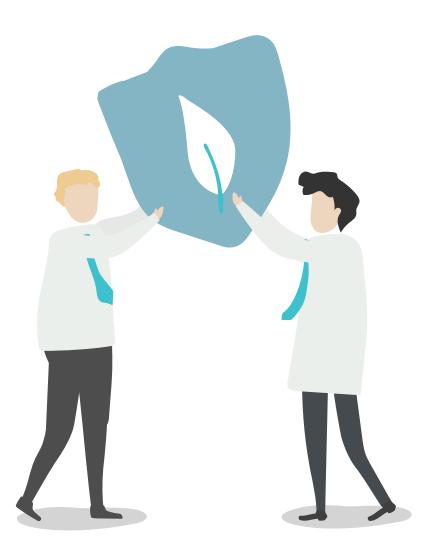
### **ACKNOWLEDGE OF PRIVACY PRACTICES**

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



## **AUTHORIZATION**

# DAWN BOVA, D.M.D.

**Family & Cosmetic Dentistry** 

Authorization To Release Dental Information		
authorize	to release info	rmation for:
Patient name:	Date of Birth:	imadon ioi.
Previous name:	2333 51 2.1311	
request and authorize the above-named release all X-rays to:	d doctor or health care provider to transfer re	ecords and
DAWI	N 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