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	Epilepsy	Kidney Disease	Stomach Problems
Allergies:	Excessive Bleeding	Liver Disease	Stroke
	Fainting	Mental Disorders	Tuberculosis
	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
Cancer	Hepatitis	Rheumatic Fever	
Diabetes	High Blood Pressure	Rheumatism	
Dizziness	Jaundice	Sinus Problems	

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 **$100** cancellation fee for any appointment that is cancelled or rescheduled with a **48-office hour** period.

Signature Date

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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.

Patient`s 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 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