LANCE C. KOVAR, DDS, PLLC

A Beautiful Smile. Today, It's Easier Than Ever.

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.

Drivers License _____exp_____

Social Security Number_____

Birthdate_____

Patient Information

Name_____
Last *First* *MI*

Address_____ Apartment #_____

City_____ State_____ Zip_____

Sex □ M □ F □ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered

Home Phone(_____)_____ E-mail_____

Cell Phone #1 (_____)_____ Cell #2 (_____)_____

May we contact you by: □ Text □ E-Mail

Employer_____Work Phone #(_____)_____

Spouse Name:_____ Phone#_____

Parent's (if Minor)_____ Phone#_____

Person to contact in case of emergency_____Phone (_____)_____

Insurance Information

Name of Insured_____Relation to Patient_____

Birthdate_____Social Security #_____Effective Date_____

Insurance Company_____ Group Name_____

Group #_____ ID#_____

I authorize release of information related to any claims and payment of benefits to the dental office:

_____

Responsible Party

Name of Person
Responsible for this Account_____Relation to Patient_____

Address_____Home Phone (_____)_____

Drivers License #_____ Birthday_____

Employer_____ Work Phone (_____)_____

Currently a patient in our office? □ Yes □ No E-mail_____

Primary Care Physician

Physicians Name_____Phone#_____

Address_____Suite#_____

_____State_____Zip_____

Specialist_____Phone#_____

Adress_____Suite#_____

_____State_____Zip_____

Dental History

Reason for todays visit_____Date of last dental care_____

Former Dentist_____Date of last dental x-rays_____

Address_____ Phone # (_____)_____

_____ State_____ Zip_____

Check ☑ if you have or have had any of the following:

□ Anemia	□ Cortisone Treatments	□ Hepatitis	□ Respiratory Disease
□Arthritis, Rheumatoid	□ Cough, Persistent	□ High Blood Pressure	□ Rheumatic Fever
□ Artificial Heart Valves	□ Diabetes	□ HIV/AIDS	□ Scarlet Fever
□ Artificial Joints, Pins, ect.	□ Dizziness	□ Jaw Joint Pain	□ Sensitive Teeth
□ Asthma	□ Dry Mouth	□ Kidney Disease	□ Shortness of Breath
□Alzheimers/Dementia	□ Epilepsy	□ Liver Disease	□ Skin Rash
□ Back Problems	□ Fainting	□ Low Blood Pressure	□ Stroke
□ Blood Disease	□ Glaucoma	□ Mitral Valve Prolapse	□ Swelling of Feet or Ankles
□ Cancer	□ Headaches	□ Thyroid Problems	□ Tobacco Habit
□ Chemical Dependency	□ Head Injuries	□ Organ Transplant	□ Tonsilectomy
□ Chemotherapy	□ Heart Murmur	□ Periodontal Disease	□ Tuberculosis
□ Circulatory Problems	□ Heart Problems	□ Radiation Treatment	□ Fear of Dentist
□ Congenital Heart Lesion	□ Excessive Bleeding	□ Autism	□ADD/ADHD

□ Aspirin taken daily □ Blood Thinners _____

(Women) Are you pregnant? □ Yes □ No

List medications you are currently taking & the correlating diagnosis: Allergies/Sensitivity

_____ _____

_____ _____

_____ □ Aspirin Allergy

_____ □ Codeine Allergy

_____ □ Keflex Allergy

_____ □ Penicillin Allergy

_____ □ Vicodin Allergy

Authorization, Release and HIPAA

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibilty to inform my doctor if I or my child (if a minor) ever have a change in health.
For patients/guarantors that Do Not carry dental insurance, payment is expected in full at the time of the visit. For patients/guarantors that Do carry dental insurance, we will help prepare the insurance forms, assist in making collections from insurance companies, and will credit any such collections to the patient's account. The patient understands that all dental services furnished can be charged directly to the insurance Company, but the patient is responsible for payment of all dental services Not Covered by the insurance company. This dental office cannot render services on the assumption that all charges will be paid by an insurance company.

We accept Cash, Check and Credit Cards. Financing is available through CareCredit. I grant my permission to telephone me at home or at my work to discuss matters related to this form. I have read and agree to their content.

I acknowledge I have seen a copy of the HIPAA Policy. A copy will be provided if requested.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

Please Print Name Signed Above Date

Payment is due in full at time of treatment unless prior arrangements have been approved.