KoVar DENTAL

PATIENT INFORMATION

□ Mr
□ Mrs
□ Ms   Name_____ Sex □ M □ F
□ Miss   *Last*   *First*   *MI*   *Preferred Name*
□ Dr

Address_____Apt/Lot #_____

City_____State_____Zip_____

Primary Phone # (____)_____Secondary Phone # (____)_____

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

Employer_____Work Phone # (____)_____

Birthdate_____Social Security Number_____Drivers License_____

Marital Status: □ Married □ Single □ Partnered □ Widowed □ Divorced □ Separated □ Minor

Emergency Contact_____Phone # (____)_____

Pharmacy_____Phone # (____)_____

RESPONSIBLE PARTY (If other than Patient)

Name_____Relationship to Patient_____
    Last   *First*   *MI*

Address_____Apt/Lot #_____

City_____State_____Zip_____

Primary Phone # (____)_____Secondary Phone # (____)_____

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

DENTAL HISTORY

Reason for visit_____Date of last dental care_____

Former Dentist_____Date of last dental x-rays_____

Address_____ Phone # (____)_____
                    City   *State*

✓ Check if you have any of the following dental conditions

□ Bad Breath   □ Clicking/Popping Jaw   □ Grinding/Clenching teeth   □ Periodontal Disease
□ Bleeding Gums   □ Food Packing between teeth   □ Loose Teeth/Broken Fillings   □ Ulcers/Sores

Please list any other dental concerns_____

_____

MEDICAL HISTORY

Physicians Name_____Date of last visit_____

Address_____ *City*   *State*____Phone # (____)_____

Are you curently under the care of a physician? □ Yes □ No

If yes, please explain_____

Have you had a serious illness, operation or been hospitalized in the past 5 years? □ Yes □ No

If yes, please explain_____

Women Only: Pregnant? □ Yes □ No   Trimester/Due Date_____ Nursing? □ Yes □ No

✓ Check if you have any of the following conditions. **Please include dates of condition.**

□ Abnormal Bleeding	□ Chemical Dependency	□ Glaucoma	□ Radiation Treatment
□ A-Fib	□ Chemotherapy	□ Head Injury	□ Respiratory Disease
□ Anemia	□ Circulatory Problems	□ Heart Attack	□ Rheumatic Fever
□ Arthritis	□ Congenital Heart Defect	□ Heart Murmur	□ Migraines
□ Artificial Heart Valves	□ Cortisone Treatments	□ Hepatitis	□ Shortness of Breath
□ Artifical Joints	□ COPD	□ HIV/AIDS	□ Skin Rash
□ Asthma	□ Depression	□ High Blood Pressure	□ Stroke
□ Autism	□ Diabetes Type I or II	□ Kidney Disease	□ Swollen Feet/Ankles
□ Alzheimers/Dementia	□ Dizziness	□ Liver Disease	□ Thyroid Problems
□ Anxiety	□ Dry Mouth	□ Low Blood Pressure	□ Tobacco/Vape Use
□ Back Problems	□ Eating Disorders	□ Mitral Valve Prolapse	□ Tuberculosis
□ Bipolar Disorder	□ Epilepsy/Seizures	□ Organ Transplant	□ Tumors
□ Blood Disease	□ Fainting	□ Osteoporosis	□ Ulcers/Sores
□ Cancer	□ Fibromyalgia	□ Pacemaker	

MEDICATIONS

Please list any medications or supplements that you are currently taking_____

_____

_____

_____

Aspirin Taken Daily? □ Yes □ No

Blood Thinners? □ Yes □ No

Do you take Pre-med Antibiotics for dental treatment? □ Yes □ No

For Office Use Only
□ Provided Medication List
□ Emailed Medication List

ALLERGIES

✓Check if you have any of the following allergies   □ Please list any other allergies or sensitivities

□ Aspirin Allergy   □ Latex (rubber) Allergy

□ Codeine Allergy □ Local Anesthetics   _____

□ Iodine Allergy   □ Penicillin Allergy   _____

□ Keflex Allergy   □ Sulfa   _____

DENTAL INSURANCE INFORMATION

Subscriber's Name_____
<div style="text-align:center"><i>Last   First   MI</i></div>

Relationship to Patient_____

Subscriber's Birthdate_____Subscriber's Social Security Number_____

Dental Insurance Company_____Group Name_____

Group #_____ID # _____Effective Date_____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. I understand that it is my responsibility to notify the office of any changes to my or my child/dependent's medical status.

I understand that I have certain right to privacy regarding my protected health information. These rights are give to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protect health information to carry out:
 Treatment
 Obtaining Payment from third party payers
 Day to day healthcare operation of your practice

I have also been given the right to view and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA.

I understand that PAYMENT IS DUE AT THE TIME OF TREATMENT, unless prior arrangements have been approved.

_____
Print Patient Name

_____
Patient/Guardian Signature   Date

I certify that I am covered by the insurance company listed above and I directly assign Dr. Lance Kovar all insurance benefits, otherwise payable to me.

I understand that Dr. Kovar's staff will help prepare the insurance forms, assist in making collections from insurance companies, and will credit any such collections to my account.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover.

I understand that dental services can not be rendered on the assumption that all charges will be paid by an insurance company. I understand that I am responsible for payment of all dental services not covered by my insurance company.

I hereby authorize Dr. Kovar to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Print Patient Name

_____
Patient/Guardian Signature   Date