



**John G. Fatse DMD LLC**

**John S. Scovic DDS**

Cosmetic & Reconstructive Family Dentistry

Date: \_\_\_\_\_

**M F**

\_\_\_\_\_  
Last Name                      First                      Middle                      Date of Birth      Sex      Marital Status                      SSN

\_\_\_\_\_  
How would you like to be addressed?                      Email Address                      Cell Phone Number

\_\_\_\_\_  
Home Address                      City                      State                      Zip Code                      Home Phone Number

\_\_\_\_\_  
Name of Employer                      Occupation

\_\_\_\_\_  
Business Address                      City                      State                      Zip Code                      Work Phone Number

**Insurance Information (Please fill out secondary insurance on the back)**

\_\_\_\_\_  
Insured Member Last Name                      First                      Relationship                      SSN                      Date of Birth

\_\_\_\_\_  
Name of Employer                      Occupation                      Business Phone Number

\_\_\_\_\_  
Dental Insurance Co. Name                      Insurance Co. Address                      Insurance Co. Phone Number

\_\_\_\_\_  
Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

**How did you hear of our office?**

**Person responsible for account, if patient is a minor:**

\_\_\_\_\_  
Last Name                      First                      Middle                      Relationship

**Patient Signature:**

\_\_\_\_\_  
Sign Name                      Date

If patient was assisted with this form, enter name of person assisting:

\_\_\_\_\_  
Print Name                      Sign Name                      Date

**Patient Medical History**

Patient Name:

Birth Date:

Date Created:

Are you under a physician's care now?  Yes  No If yes

Have you ever had a serious head or neck injury?  Yes  No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes

Do you use tobacco?  Yes  No

Are you using any medications, pills or drugs?

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Sulfa Drugs

Local Anesthetics like Novocaine

Clindamycin

Amoxicillin

Approximate date of last dental visit and reason for today's visit:

Dental Health

Do you clench or grind your teeth?  Yes  No

Do your gums ever feel tender or swollen?  Yes  No

Do you have pain in your jaw joints?  Yes  No

Do foods or temperatures cause discomfort?  Yes  No If yes

Do you avoid chewing or brushing any part of your mouth due to pain?  Yes  No If yes

Have you ever had a serious problem associated with dental treatment?  Yes  No If yes

Have you ever had a previous experience at the dentist that was a reason not to return?  Yes  No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive  Yes  No

Anemia  Yes  No

Blood Disease  Yes  No

Bruises Easily  Yes  No

Excessive Bleeding  Yes  No

Fainting Spells/Dizziness  Yes  No

Hepatitis B or C  Yes  No

High Blood Pressure  Yes  No

Low Blood Pressure  Yes  No

Artificial Heart Valve  Yes  No

Heart Attack/Heart Failure  Yes  No

Heart Murmur  Yes  No

Heart Pacemaker  Yes  No

Heart Trouble/Disease  Yes  No

Irregular Heartbeat  Yes  No

Mitral Valve Prolapse  Yes  No

Stroke  Yes  No

Asthma  Yes  No

Breathing Problems  Yes  No

Emphysema  Yes  No

Frequent Cough  Yes  No

Lung Disease  Yes  No

Sinus Trouble  Yes  No

Alzheimer's Disease  Yes  No

Drug Addiction  Yes  No

Epilepsy/Seizures  Yes  No

Psychiatric Care  Yes  No

Diabetes  Yes  No

Kidney Disease  Yes  No

Liver Disease  Yes  No

Stomach/Intestinal Disease  Yes  No

Thyroid Disease  Yes  No

Cancer/Cancer Treatment  Yes  No

Radiation Treatment  Yes  No

Joint Replacement  Yes  No

Osteoporosis  Yes  No

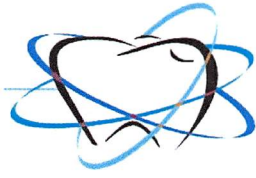
Have you ever had any serious illness not listed above or is there any other information you would like to share with us?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: \_\_\_\_\_



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### Payment Options

**Payment in Full:** Cash/Check/Debit/Credit/Health Savings Account on day of treatment.

- **Payment Plan:** (Balances over \$500.00): Deposit of 50% of estimated treatment cost is due the day of procedure and remaining balance is due within 30 days of treatment. This payment option requires a signed credit/debit card authorization.
- **Outside Financing (Care Credit):** 0% financing over 12-24 months. No pre-payment penalties, subject to credit approval.

I have read and understand these payment options. All insurance payments are estimated and any difference or non-covered service is the patient's responsibility. I understand that unpaid balances are subject to a finance charge of 1% per month (12% APR) if balance is not paid after 30 days. By applicable state law, after 60 days we reserve the right to charge 15% in collection costs in addition court costs and a reasonable attorney fee for any unpaid balance.

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Patient/Guardian Signature

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Date

### Appointment Agreement

We understand that your time is valuable and we are constantly striving to make your experience here more pleasant. We make every effort to stay on time so that our patients will not have to wait unnecessarily. Your appointment is a commitment of time between you and our office and we ask that you make every effort to honor that commitment. If you find that you cannot keep your appointment, we do require a minimum notice of 48 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 48 hours, you may be subject to a \$75.00 cancellation charge.

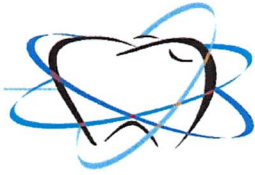
By signing below, I agree to fulfill my obligation as a patient and agree to the "broken appointment" fee should I not give proper notification.

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Signature of patient or responsible party

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Date



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#### HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review 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 you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_