Date

GETTING TO KNOW YOU AS OUR PATIENT

Patient Name		Social Security Number	Home Phone ( )
Home Address		City, State, Zip	Birthdate / /
Marital Status: ☐ Single ☐ Married	☐ M ☐ F	Email:	Driver's License and State

Primary Insurance Company _____ Group _____ Subscriber _____

Secondary Insurance Company _____ Group _____ Subscriber _____

Responsible Party (if other than Patient)

Name	Social Security Number	Home Phone ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status: ☐ Single ☐ Married	Relationship to Patient	Driver's License and State
Employer	Occupation	Work Phone ( )
Business Address	City State Zip	
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address	City State Zip	

How did you hear about our office?

(Check only one)

☐ Referred by a Friend — If it was a friend, whom may we thank for referring you? _____

☐ Yellow Pages ☐ Relative ☐ Insurance Plan ☐ TV/Radio Ad

☐ Newspaper Ad ☐ Direct Mailing ☐ Sign by Building ☐ Other _____

CONSENT

* I will answer all health questions to the best of my knowledge. _____
(Initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____

** Signature* *Date* *Relationship to Patient*

AGREEMENT TO PAY

I agree to pay for all services rendered. In the event that payment is not made within thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the agreed upon fee schedule.

Payment Preference ☐ Cash/Check on day of treatment ☐ Credit Card ☐ Debit Card

_____ _____

** Signature* *Date*

There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time

PATIENT'S DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last Visit_____ Date of Last Cleaning _____

Reasons for changing dentists: _____

Have you had any problems with past dental treatment? _____

Are you nervous about seeing a dentist? ☐ Yes! ☐ No If yes, please tell us why: _____

How often do you brush?_____ Do you floss? ☐ Yes ☐ No How often? _____

(Please circle each.)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums fell tender or swollen.
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straighter.
Y N I want my teeth whiter.

What are your dental priorities? _____
(e.g.: appearance, dental health, financial considerations, etc.)

PATIENT'S MEDICAL HISTORY

I consider my health to be *(Please check one)*: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you had any of the following? *Please circle Y for yes and N for no.*

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: Hip-Knee_____ Other_____
16. Y N I smoke or use chewing tobacco. If yes, how much per day? How man years?
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery. Year_____ Type of operation_____
21. Y N Do you have any other medical problem or medical history NOT listed on this form?
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type _____
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis ("Mono")
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Veneral Diseases
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation/Therapy
35. Y N History of Drug Addiction
36. Y N AIDS/HIV
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

WOMEN:

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

Doctor Notes Only:

Year_____ Type of operation_____

Are you allergic to any of the following?
Please circle Y for yes or N for no

44. Y N Asprin/Ibuprofen
45. Y N Sulfa Drugs/Sulfites/Sulfides
46. Y N Penicillin
47. Y N Codeine
48. Y N Latex, Metals, Plastics
49. Y N Local Anesthetics (Novocaine)
50. Y N Other Medications Which ones? _____

_____

Please list all medications you are currently taking:

_____

_____

_____

_____

Physician's Name _____ Phone _____

Address _____ Fax _____

In the event of an emergency, please contact:

Name_____ Relationship_____ Phone _____

Name_____ Relationship_____ Phone _____

Medical Health Reviewed by:

X _____ ___/___/___
Doctor's Signature *Date*

X _____ ___/___/___
Patient's Signature *Date*

X _____ ___/___/___
If Patient is a Minor, Parent/Guardian Signature *Date*

1. DENTAL EXAMINATION AND TREATMENT PLAN

California Law requires that the dentist examine and diagnose all new patients **prior to delegating general supervision duties to auxiliaries including hygienist for cleaning.**

2. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that **were not discovered during examination.** For example, **root canal therapy may follow routine restorative procedures.** I give my permission to the Dentist to make any/all changes and additions as necessary, **after explaining the reason and obtaining my consent.**

3. DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

4. PERIODONTAL LOSS (TISSUE & BONE)

I understand that periodontal disease is a condition of the gums and bone and it can lead to eventual tooth loss. Alternative treatment plans have been explained to me, including scaling, root planning, medicinal irrigation, and gum surgery, replacement and/or extraction. I understand that undertaking any dental procedures my not prevent continued bone loss. I understand that I may require constant maintenance.

5. FILLINGS

I understand that care must be exercised in chewing on new fillings especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. **I understand that significant sensitivity is a common after effect of a newly placed filling.**

6. CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying permanent cementation. **Endodontics (root canal) may be necessary after or during crown cementation.**

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that occasionally root canal filling material may extend through the root which does not necessarily affect the success of the treatment. Occasionally, additional surgical procedures may be necessary following root canal treatment (Apicoectomy). **I understand that the tooth may be lost despite all efforts to save it. In some cases, a previously treated tooth may require re-treatment by a specialist or may require extraction. Following completion of endodontic therapy, a tooth should be restored as soon as possible to protect it from fracture or decay.**

8. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal, therapy, crown and periodontal surgery, etc.). I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. **I understand I may need further treatment by a specialist if complications arise or following treatment, the cost of which is my responsibility.**

9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. **This is not included in the original denture fee.** I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitting dentures. If a remake is required due to my delays of more than 30 days there will be additional charges.

10. COSMETIC SERVICES

Cosmetic services may not be covered by insurance plans. This includes porcelain facings on molars, cosmetic bleaching, cosmetic bonding and laminates.

11. OPTIONAL TREATMENT

The need for treatment that is excluded as a benefit by insurance companies will be explained to me. If I choose to proceed, the use and cost of noble metals, including gold, will be with my consent.

I hereby authorize any of the doctors to proceed with and perform the dental restorations and treatments explained to me. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees.

SHOULD ANY DISPUTE ARISE OVER DENTAL SERVICES PROVIDED TO ME, THAT IS WHETHER ANY DENTAL SERVICE RENDERED WAS ALLEGEDLY UNNECESSARY, UNAUTHORIZED OR WAS IMPROPERLY, NEGLIGENTLY, OR INCOMPETENTLY PERFORMED, SAID DISPUTE WILL BE SUBMITTED TO PEER REVIEW BY THE SAN FRANCISCO DENTAL SOCIETY, A COMPONENT OF THE AMERICAN DENTAL ASSOCIATION. THE DECISION OF PEER REVIEW SHALL BE BINDING ON BOTH PARTIES. I HAVE READ, UNDERSTOOD, AND AGREED TO THE ABOVE.

Signature: _____ Date: _____

Denys Kovalchuk DDS
591 REDWOOD HIGHWAY
BLDG 2000 SUITE 2110
MILL VALLEY, CA 94941
P. 415 381-4321 / F. 415 381-4056

PAYMENT POLICY ACKNOWLEDGMENT

Our fees reflect our Professional Commitment to Excellence. Payment is expected at the time of Service. For your convenience we offer the following methods of Payment.

A.) Cash, Check, Money Order and/or Credit Cards (Visa, Master Card.)
B.) Pay ½ at the initial appointment, and balance ***Prior*** to completion; upon approval of office management.
C.) For patients using Insurance, same as above. For larger cases, we can accept assignment of benefits with payment of your deductible and your ***estimated patient co-payment*** due at each visit.

Our Front Office and Management team understand insurance and we will be glad to assist you in obtaining the maximum benefit specified in your contract. It is important that you realize, however that…

1.) Your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. *As a courtesy, we will help you file your insurance claim.* PPO (Preferred Provider) are contracted at reduced fees. In the case of non-payment from your insurance company, you are responsible for the full PPO contracted fee, which is stated as the *"Doctors Fee".*

2.) Our fees generally, but not necessarily, fall within the Usual, Customary and Reasonable (UCR) rate determined by your carrier.

3.) Not all dental services are covered benefits (i.e. Veneers, tooth colored fillings, whitening. There may be an extra co-payment for white fillings, all porcelain crowns (Emax), Cast Porcelain Crowns or Bridges since the laboratory's fees are higher for such procedures.

4.) You (not the insurance company) are responsible to us for all the fees for services rendered to you.

5.) An ESTIMATE will be given to you of the benefits that the insurance company is expected to pay and any co-payments that are expected from you at the time the service is rendered. ***Estimates, quotes and/or Pre-determinations from your Insurance company or by our office is NOT a Guarantee of Payment in Part or in Full by your Insurance Company. You, Not the Insurance Company, Are fully responsible for any and all balances left on your account after Insurance has paid or Denied your Claim.***

6.) A **$75 late fee** will be charged for all appointments that are not cancelled **48 hours** in advance. Cancellations must be made during our business days, Mon-Thu.

All accounts that remain unpaid for 90 Days will be referred to collections.

WE APPRECIATE THE OPPORTUNITY TO SERVE YOU

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND THAT A COPY WILL BE GIVEN TO ME FOR MY REFERENCE

Patient Signature _____ **Date** _____

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591 REDWOOD HIGHWAY
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MILL VALLEY, CA 94941
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www.KovalchukDDS.com

In order to process your registration, the law requires that your consent be obtained regarding the use and disclosure of your personal information, including information submitted through this registration process and/or that obtained by your health care provider in the process of providing treatment.

By signing at the bottom of this Consent, you agree to the following terms and considerations, enforced by Dr. Denys Kovalchuk, DDS.

I understand and agree that my personal (demographic) and health information may be used and disclosed by Dr. Denys Kovalchuk, DDS to carry out treatment, payment, or other health care operations. For purposes of this consent, health information means all information that identifies me as an individual (or can reasonably be used to identify me as an individual) and relates to my past, present or future physical or mental health, health care services provided to me, examinations and treatment plans, and/or payment for the provision of health care services proposed or provided to me. I authorize Dr. Denys Kovalchuk, DDS to disclose my personal and health information to another health care provider, a health care service plan or an insurance company for purposes of treatment, evaluation or investigating any claim for benefits or as otherwise needed to administer any health care coverage I may have.

I also understand that my personal and medical information may be accessed and used by business associates contracted with my selected provider to provide administrative services and/or system support; provided, however, that such business associates must agree to use this information only as necessary to fulfill their respective obligations and to not further disclose my personally identifiable information for any other purpose.

I understand that I have the right to request that Dr. Denys Kovalchuk, DDS restrict how my health information is used or disclosed to carry out treatment, payment and/or health care operations. I understand that Dr. Denys Kovalchuk, DDS is not required to agree to such requested restrictions; however, if Dr. Denys Kovalchuk, DDS to a requested restriction, the restriction shall be binding on Dr. Denys Kovalchuk, DDS and his contracted business associates.

I understand that I have the right to ask Dr. Denys Kovalchuk, DDS for a more complete description of his privacy practices and may review this information prior to providing this consent. I also understand that I have the right to revoke this consent in writing at any time, except to the extent that Dr. Denys Kovalchuk, DDS or his contracted business associates has already acted in reliance on this consent.

This consent will be effective immediately and will remain in affect until terminated by me. I understand that Dr. Denys Kovalchuk, DDS may refuse to provide or continue treatment without the provision of a valid consent.

I have read, understand, and agree to the consent provisions set forth above.

Signature _____ Print Name _____

Date _____

Denys Kovalchuk, DDS General & Cosmetic Dentistry

591 Redwood Hwy, Ste 2110 Mill Valley, Ca 94941

(415) 381-4321

Patient Acknowledgement of Receipt of

Dental Materials Fact Sheet and Privacy Practices

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Material Facts Sheet. In addition, the Health Insurance Portability and Accountability Act (HIPPA) require, effective April 14, 2003, that patients be given a copy of our Notice of Privacy Practice.

Please print and sign you name below.

I, _____acknowledge I have received from this office:

1. A copy of the Dental Materials Facts Sheet
2. The Notice of Privacy Practice

_____ _____

Patient Signature or Representative Date

If signed by a representative of the patient, describe the representative's authority to act for the patient._____.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notices, but acknowledgement could not be obtained because:

Individual Refused

Communication barriers prohibited obtaining acknowledgement

An emergency situation prevented us from obtaining acknowledgement