JOVAN Prosthodontics

change your smile, change your life

Patient Information: Today's Date: ___/___/_____

Name: _____ _____ _____
Last First Middle

I prefer to be called: _____ ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Age: _____ Driver's License #: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

SSN#: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone Number: _____

Alternate Phone Number: _____

Emergency Contact Person: _____ _____ _____
Name Relation Phone

Employer: _____ Years at Employer: _____

Occupation: _____

General Dentist: _____ Medical Primary Care Doctor: _____

Last Dental Treatment Rendered: _____ Date: _____

Family Member Seen by Us: _____

Spouse Information: *(Leave Blank if Not Applicable)*

Name: _____ _____ Date of Birth: _____/_____/_____
Last First

Spouse's Phone Number: _____ Spouse's SSN#: _____

Spouse's Employer: _____ Years At Employer: _____

Spouse's Email Address: _____

How Did You Hear About Us?

☐ Referring Dental Office ☐ Previous Patient ☐ Online ☐ Other: _____

Who Will Be Responsible for Your Account: ☐ Self ☐ Parent/Guardian *(if Minor)* ☐ Other

**If Parent, Guardian, or Other – Complete Following Section:*

Name: _____ _____ Date of Birth:_____/_____/_____ Relation: _____
Last First

Home Address: _____

Insurance Information: *(We only courtesy file to Primary)*

DENTAL:

Insurance Name: _____ Insurance Phone Number: _____

Insurance Company Address: _____

Member ID#: _____ Group #: _____

Policy Holder's Name: _____ _____ Date of Birth: _____/_____/_____
Last First

Policy Holder's Employer: _____ Policy Holder's SSN#: _____

Policy Holder's Address: *(If Different from Patient)*: _____

Relationship to Patient: _____

MEDICAL:

Insurance Name: _____ Insurance Phone Number: _____

Insurance Company Address: _____

Member ID#: _____ Group #: _____

Policy Holder's Name: _____ _____ Date of Birth: _____/_____/_____
Last First

Policy Holder's Employer: _____ Policy Holder's SSN#: _____

Policy Holder's Address: *(If Different from Patient)*: _____

Relationship to Patient: _____

Health History:

Height: _____ Weight: _____ Your Current Physical Health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a Physician? ☐ YES ☐ NO If "Yes", please explain: _____

_____

Are you taking any prescription or Over the Counter Medications? ☐ YES ☐ NO If "Yes", please list: _____

_____

Have you ever had/have any of the following diseases, illnesses, or medical complications?

☐ Y ☐ N Artificial Limbs/Joints/Valves
☐ Y ☐ N Arthritis
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Diabetes
☐ Y ☐ N Drug or Alcohol Abuse
☐ Y ☐ N Epilepsy/Seizure/Fainting Spells
☐ Y ☐ N Heart Attack/Stroke
☐ Y ☐ N Hemophilia/Abnormal Bleeding
☐ Y ☐ N HIV+/AIDS
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Mental Health Issue/Anxiety/Depression
☐ Y ☐ N Severe/Frequent Headaches
☐ Y ☐ N Ulcers/Colitis
☐ Y ☐ N Cancer/Chemotherapy
☐ Y ☐ N Hospitalized for any reason
☐ Y ☐ N Unhealed/recurrent Injuries
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Chest Pain/Angina
☐ Y ☐ N Dialysis
☐ Y ☐ N Cardiac Pacemaker
☐ Y ☐ N Heart Surgery
☐ Y ☐ N Pneumonia/Bronchitis/Chronic Cough
☐ Y ☐ N Contagious Diseases
☐ Y ☐ N Snoring
☐ Y ☐ N Sleep Apnea/ CPAP
☐ Y ☐ N Tumor/Growth
☐ Y ☐ N Do you use Alcohol – Drinks per Week _____
☐ Y ☐ N Do you smoke Cigarettes – per Day _____
☐ Y ☐ N Bruise easily
☐ Y ☐ N Eye Disease/Glaucoma

☐ Y ☐ N Anemia
☐ Y ☐ N Asthma
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Difficulty Breathing/Other Lung Issue
☐ Y ☐ N Emphysema
☐ Y ☐ N Fever Blisters/Herpes
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Hepatitis/Jaundice/Liver Disease
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Rheumatic/Scarlet Fever
☐ Y ☐ N Shingles
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Radiation Treatment
☐ Y ☐ N General Anesthesia Issues
☐ Y ☐ N Growth/Sore Spots in Mouth
☐ Y ☐ N Low Blood Sugar
☐ Y ☐ N High Cholesterol
☐ Y ☐ N Irregular Heart Beat
☐ Y ☐ N Osteoporosis/Osteopenia
☐ Y ☐ N Osteonecrosis
☐ Y ☐ N Stomach Ulcers/Acid Reflux
☐ Y ☐ N Sexually Transmitted Diseases
☐ Y ☐ N Problems with Immune Systems
☐ Y ☐ N Delay in Healing
☐ Y ☐ N Emphysema
☐ Y ☐ N Do you use Marijuana
☐ Y ☐ N Do you use recreational drugs
☐ Y ☐ N Contact Lenses
☐ Y ☐ N Gallbladder Trouble

WOMEN ONLY:

☐Y☐N Possibility of Pregnancy
If "Yes" – Expected Delivery Date: _____

☐Y☐N Are you Nursing
☐Y☐N Are you taking birth control

Are You Taking Any of the Following?

☐Y☐N Blood Thinner
☐Y☐N Natural/Herbal/Homeopathic Product
☐Y☐N Tranquilizers/Narcotics
☐Y☐N Diet Pill
☐Y☐N Bone Density Medications
☐Y☐N Sleeping Pills/Anti-Depressants

Are You Allergic to any of the Following?

☐Y☐N Local Anesthetic (numbing meds)
☐Y☐N Penicillin
☐Y☐N Codeine
☐Y☐N Tetracycline
☐Y☐N Erythromycin
☐Y☐N Valium/Other Tranquilizers
☐Y☐N Eggs
☐Y☐N Other: _____
☐Y☐N Aspirin
☐Y☐N Other Antibiotics
☐Y☐N Sulfa Drugs
☐Y☐N Any Metal/Plastic
☐Y☐N Latex
☐Y☐N Soy
☐Y☐N Sulfites

Dental History:

Your current dental health is: ☐Good ☐Fair ☐Poor

Do you require any antibiotics for dental treatments? ☐Y☐N

Do you like your smile? ☐Y☐N

Do your gums bleed? ☐Y☐N

Do you use chewing tobacco products? ☐Y☐N

Have you ever had an injury to your: ☐Mouth ☐Jaw

Do you have any missing or extra permanent teeth? ☐Y☐N

Have you ever had a serious/difficult problem with any previous dental work? ☐Y☐N

Have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐Y☐N

Have you been evaluated for orthodontic treatment? ☐Y☐N

Have you been let go from a dental practice as a patient? ☐Y☐N

JOVAN Prosthodontics

Personal History

Please tell us your main concern and what you feel has lead you to the condition you are in now. How long have you been in your present condition?

_____

_____

_____

_____

_____

Function

How has this condition affected your ability to function and your health?

_____

_____

_____

_____

_____

Diagnosis

Have you been or are you presently diagnosed and being treated with any condition that has affected your physical and mental health?

_____

_____

_____

_____

_____

Patient Signature: _____

Date: _____

JOVAN
Prosthodontics
Dr. Ace Jovanovski, DMD, MCDT

AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTY

I authorize Jovan Prosthodontics to release information to third parties, as follows:

Name: _____ **DOB** __/__/__ **Relationship:**_____

Name: _____ **DOB** __/__/__ **Relationship:**_____

Name: _____ **DOB** __/__/__ **Relationship:**_____

Circle One: **No Restrictions**
Limited (please specify)

_____ _____
Patient Signature **Date**

_____ _____
Personal Representative Signature (if applicable) **Relationship to Patient**

FOR OFFICE USE ONLY

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

Circle One:
Individual refused to sign
Communication barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (please specify)

Witnessed by: _____ **Date**___/___/___

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Photo Release

We value our patients' right to privacy and confidentiality, and we take our responsibilities under HIPAA and the Texas Medical Records Privacy Act very seriously. The practice exercises great care in the use of patient images and patient identities.

By signing below, you understand that this authorization may be revoked at any time merely by notifying our office in writing that you wish to no longer allow your photographs to be shared.

Your willingness to allow photography release will have no effect on the treatment or care you receive from our office and staff.

_____ I give my permission to Dr. Ace Jovanovski and Jovan Prosthodontics to use my diagnostic photographs, radiographs, and study casts for diagnostic and educational purposes. These items may also be shared with referring dentists, doctors, and colleagues for diagnostic and educational purposes.

_____ I give my permission to Dr. Ace Jovanovski and Jovan Prosthodontics to use my before and after photographs to publish in internet illustration, promotional, editorial and advertising in photographs and details of my treatment without restrictions as to alteration.

_____ I give my permission to Dr. Ace Jovanovski and Jovan Prosthodontics to use my photographs in social media publications and brief descriptions.

_____ I **do not** give my permission to share any photographs taken by Dr. Ace Jovanovski or Jovan Prosthodontics to any outside providers or publications.

_____
Print Patient Name

_____ _____
Patient (Guardian) Signature Date

FINANCIAL POLICY

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. To prevent any misunderstanding and to better serve you, we ask that all patients read and sign our **FINANCIAL POLICY**. If you have any questions, please ask our team member at the front desk. **By providing your signature, this indicates that you have read, fully understand, and fully agree to our policies.**

PAYMENT: Payment is due **at the time of service**. We accept all major credit cards, cash, checks, and third-party financing as forms of payment. If needed, we will gladly assist you in trying to obtain third party financing, including CareCredit. (Our office offers the 6 months no interest plan with CareCredit)

INSURANCE: While we are not contracted with any insurance policies, we can courtesy file to your primary insurance at your request. We will include any information necessary, including x-rays to aid in helping you attain the full insurance benefit due to you. Insurance benefits will be paid as a reimbursement to you directly from your insurance provider.

RETURNED CHECKS: A **$50** returned check fee will be assessed to all returned checks and no future checks can be received as payment.

CANCELLATIONS/FAILED APPOINTMENTS: We request **48-hours notice** if you are canceling an appointment. After the first cancelled or failed appointment (without proper notice), a **$50** cancellation fee may be assessed for cancelled or failed appointments without 48-hour notice.

FOR OPERATIVE AND SURGICAL APPOINTMENTS CANCELLED/MISSED (without proper notice), a fee of **10% of the total case fee** will be added to your balance. In addition, if missed or canceled procedure involves an outside anesthesiologist, a fee of **85% of total anesthesia fee** will be added to your account balance.

REFUND POLICY: If a refund is issued, Jovan Prosthodontics requires a 2-week notification. We will issue you a refund minus any work completed, any parts/product ordered, and any lab time performed. **This includes a fee of $150.00 for your records appointment if one is required for your treatment. If your payment was made via a credit card transaction, a 3.5% transaction fee will be deducted from your total refund due.**

We welcome you to our practice and look forward to helping you establish a healthy, beautiful smile. If there is anything we can do to make your visit here more pleasant, please do not hesitate to ask one of our team members.

Patient Name _____ Date _____

Patient Signature _____

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Dr. Ace Jovanovski, DMD, MCDT

HIPAA PRIVACY FORM

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for Jovan Prosthodontics.

I also acknowledge, understand, and agree my information can be shared with other medical and dental providers, laboratories, and insurance companies before, during, and after my care.

Name: _____

Signature: _____ Date: _____
(Parent of Guardian if patient is a minor)