Dr. Elizabeth A. Kovalcik Inc.

250-832-3626

drekovalcik@gmail.com

OFFICE POLICIES

Appointments:
Once you have made an appointment, that time is reserved for you. If you are unable to keep the appointment, please let us know at least 24 hours in advance.

Cancellation of appointments with less than 24 HOURS NOTICE or a missed appointment may be subject to a $100.00 fee, depending on the length of the appointment canceled/missed.

Financial:
Payment is due in full for services rendered at the time of the appointment.
We do not accept payment plans at this time.

Deposits are required for large procedures (any appointment of $500 or more) on the day of the appointment. If you choose not to go forward with a procedure that includes a lab fee, the deposit will go towards the lab fee and/or any work that was done preparing for your appointment. Any remaining balance of the deposit will then be returned to the patient.

Dental Insurance:
If you have dental insurance, **the plan is a contract between yourself and the insurance company**. Please be advised, it is your responsibility to know your insurance information and limits in regard to your dental plan/coverage. Insurance companies are bound by the Personal Health Information Act and do not share that information with the dental clinic. As a courtesy to our patients, we submit insurance claims electronically to your insurance company, as well as receive direct payment for the portion that is covered by your insurance company.

Any services which are unpaid by your insurance company are your financial responsibility.

I have read and agree to these office policies:

Signature of Patient / Guardian: _____

Date: _____

Patient Information

Name:_____ Date of Birth:_____

Preferred Name:_____ Gender:_____

Home phone: _____ Cell:_____ Work:_____

Address:_____ City:_____

Postal Code: _____ Occupation:_____

Email: _____Do you prefer phone or email reminders?_____

Emergency Contact:_____ Phone number:_____

Parent / Guardian (if applicable):_____

Who may we thank for referring you to our office?_____

Release of Information: May we discuss your health care with your:

Insurance company.....Yes or No Health care provider.....Yes or No

Dental History Questionnaire

When was your last dental visit/reason:_____

Previous Dentist:_____ Date of last X – rays:_____

Please check all that apply to you:

- ○ Bleeding gums when brushing /flossing
- ○ Sensitivity to hold/colds
- ○ Reaction to dental anesthetic
- ○ Experience dry mouth
- ○ Anxiety / fear of dental visits
- ○ Food catches between teeth
- ○ Grinding or clenching
- ○ Jaw pain

Have you been treated for gum disease or been told you have bone loss around your teeth?...Yes or No

Have you ever been recommended to take antibiotics prior to dental treatment?.....Yes or No

Have you ever worn a night guard or bite appliance?.....Yes or No

Have you ever whitened (Bleached) your teeth?.....Yes or No

Medical History

Do you have or have you had any of the following? Please check all that apply to you

- ○ Arthritis
- ○ Asthma
- ○ AIDS / HIV
- ○ Anemia
- ○ Autoimmune Disease
- ○ Back / neck pain
- ○ Blood disorder
- ○ Breathing / Lung problems
- ○ Cancer
- ○ Cardiac Stent
- ○ Chemotherapy and/or Radiation Treatment
- ○ Cochlear Implant
- ○ Currently Pregnant – Date:_____
- ○ Diabetes – Type 1 or Type 2
- ○ Epilepsy
- ○ Heart Attack – Date:_____
- ○ Hepatitis A /B / C
- ○ High or Low Blood pressure
- ○ Hormone Deficiency
- ○ Infective Endocarditis
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mental Health Disorder
- ○ Pacemaker
- ○ Rheumatic Fever
- ○ Sinus Issues
- ○ Stroke - Date:
- ○ Thyroid Disease
- ○ Tuberculosis
- ○ Ulcers
- ○ Vertigo

Name of Physician:_____

Please list all medications you are currently taking:_____

_____

Is there anything else you would like us to know about your health that is not listed?_____

_____

Do you use tobacco products? Yes or No.....Frequency_____

Do you use recreational drugs? Yes or No.....if yes, what kind/frequency_____

Do you drink alcohol? Yes or No.....Frequency_____

Do you have any allergies to? Latex/Penicillin/ Sulfa Drugs/Codeine/NSAIDS(Aspirin, Ibuprofen, Naproxen etc.) Other allergies?_____

Is there anything else you would like us to know about your health that is not listed?_____

_____

Signature of Patient/Guardian:_____ **Date:**_____

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