

KOCHEVAR ENDODONTICS

10654 S River Heights Dr Suite 220
South Jordan, UT 84095
Phone: 801-282-1651 | Fax: 801-253-4320
kochevarendo.com

PATIENT INFORMATION

Patient Full Name: _____

Preferred Name: _____

Date of Birth: _____ SSN (optional): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

General Dentist: _____

Who were you referred by? Family/Friend Referring Dentist: _____
Insurance Internet

Marital Status: _____

Spouse Name: _____ DOB: _____

Spouse Phone: _____ Employer: _____

RESPONSIBLE PARTY (If Different from Patient)

Name: _____ Relationship: _____

Date of Birth: _____

Address (if different): _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: _____

Employer: _____

Subscriber Name: _____ DOB: _____

Member ID: _____ Group #: _____

Secondary Insurance Company: _____

Employer: _____

Subscriber Name: _____ DOB: _____

Member ID: _____ Group #: _____

MEDICAL HISTORY

Preferred Pharmacy: _____

Are you in good health? Yes No

Under medical treatment? Yes No If yes: _____

Taking medications? Yes No List: _____

Allergies? Yes No List: _____

Please check any condition that applies:

Anemia/Blood Disorder Arthritis Artificial Joints or Valves Bleeding Problems Cancer Diabetes Heart Problems Hepatitis Herpes High Blood Pressure H.I.V+ Osteoporoses/Osteoperia Stroke Tuberculosis

Other: _____

Are you pregnant? Yes No If yes, due date: _____

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

Professional services are rendered to the patient, not the insurance company. Insurance benefits are a contract between you and your insurance provider. As a courtesy, we will file your dental insurance claim; however, you are ultimately responsible for all charges on your account.

Payment is due at the time services are rendered unless prior written arrangements have been made. Accepted forms of payment include Cash, Check, Major Credit Cards, and CareCredit.

Any estimated insurance coverage is not a guarantee of payment. Any unpaid balance after insurance processing is the responsibility of the patient or responsible party.

Accounts over 60 days may be subject to a finance charge of 1.5% per month (18% annually). In the event of default, the undersigned agrees to pay all collection costs, court costs, and reasonable attorney fees.

I authorize payment of dental benefits directly to Kochevar Endodontics. I understand that I am financially responsible for all charges whether or not paid by insurance.

Responsible Party Name (Print): _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

By signing below, you acknowledge that you have been offered a copy of Kochevar Endodontics' Notice of Privacy Practices.

We may use and disclose your protected health information for Treatment, Payment, and Healthcare Operations as permitted by law.

Certain records related to substance use disorder diagnosis, treatment, or referral may be protected by additional federal confidentiality laws and may not be disclosed without written consent unless otherwise permitted by law.

You have the right to request restrictions, request confidential communications, inspect or obtain copies of your records, request amendments, and receive a paper copy of our Notice.

Privacy Officer: Michelle Beaves, Office Manager

Phone: 801-282-1651

Patient Name (Print): _____

Signature: _____ Date: _____