Welcome
Welcome
Welcome

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Date _____

1.IP

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME) Referred By _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account?

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

(If self, skip to next section)

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.(_____) _____

Spouse or other guarantor information (*if different from above*)

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION

1.IO

Student: ❑ Full Time ❑ Part Time ❑ Not School Info _____ (SCHOOL NAME) _____ (ADDRESS)

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY

❶

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

1.I1

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ S.S. # _____

I.D. # _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ S.S. # _____

I.D. # _____

SECONDARY DENTAL INSURANCE COMPANY

❷

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

1.I1

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ S.S. # _____

I.D. # _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ S.S. # _____

I.D. # _____

HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit

		Yes	No
99.	Are you in good health? ..... Height ____ Weight ____	❑	❑
100.	Have there been any changes in your general health in the past year?	❑	❑
101.	Are you under the care of a physician? ..... Date of last visit ____	❑	❑
	If so, for what are you being treated? ____		
102.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe ____		
103.	Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? ..... *If so, describe where* ____	❑	❑
104.	Do you have a prosthetic joint/implant? *If so, describe where* ____	❑	❑
105.	Have you had a heart valve replacement or vascular graft?	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
106	Rheumatic fever?			
107	Damaged heart valves / mitral valve prolapse?			
108	Heart murmur?			
109	High blood pressure?			
110	Low blood pressure?			
111	Chest pain / angina?			
112	Heart attack(s)?			
113	Irregular heart beat?			
114	Cardiac pacemaker?			
115	Heart surgery?			
116	Bronchitis, chronic cough?			
117	Asthma?			
118	Hay fever / sinus problems?			
119	Snoring / sleep apnea?			
120	Difficult breathing / other lung trouble?			
121	Tuberculosis?			
122	Emphysema?			
123	Do you smoke?			
124	Do you use chewing tobacco?			
125	Blood transfusion?			
126	Blood disorder such as anemia?			
127	Bruise easily?			
128	Bleeding tendency / abnormal bleed?			
129	Hepatitis, jaundice, or liver disease?			
130	Infectious mononucleosis?			
131	Gallbladder trouble?			
132	Fainting spells?			
133	Convulsions / epilepsy?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
134	Stroke?			
135	Thyroid trouble?			
136	Diabetes?			
137	Low blood sugar?			
138	Kidney trouble?			
139	Are you on dialysis?			
140	Swollen ankles, arthritis or joint disease?			
141	Stomach ulcers?			
142	Contagious diseases?			
143	Sexually transmitted diseases?			
144	Are you immunosuppressed? possibly from transplant surgery, etc.			
145	Problems with the immune system? possibly from medication / surgery, etc.			
146	Delay in healing?			
147	A tumor or growth?			
148	Radiation therapy / chemotherapy?			
149	Chronic fatigue / night sweats?			
150	Are you on a diet?			
151	A history of drug abuse?			
152	A history of alcohol abuse?			
153	Contact lenses?			
154	Eye disease / glaucoma?			
155	Mental health problems?			
156	A removable dental appliance?			
157	Pain and clicking of jaws when eating?			
158	Malignant hyperthermia?			
159	**IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat or drink in the last 6 hours?			
160	Who is driving you home?			

MEDICATION – Are you now taking or have you taken. . .

		Yes	No	NOTES
201	Any kind of medication, drug, pills?			
202	Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)?			
203	Have you ever taken diet pills?			
204	Any natural product, herbal supplement or homeopathic remedy?			
205	Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			
206	Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list:			
207	Please list any medications you are currently taking:			

ALLERGIES – Are you allergic to, or had a reaction to. . .

		Yes	No	NOTES
208	Local anesthetic (numbing med.)?			
209	Penicillin?			
210	Other antibiotics?			
211	Sulfa Drugs?			
212	Sodium pentothal, Valium, or other tranquilizers?			
213	Aspirin?			
214	Codeine or other narcotics?			
215	Other medications?			
216	Latex?			
217	Soy?			
218	Eggs / Yolk?			
219	Sulfites?			
220	Please list any allergies other than drug allergies:			

Is there any condition concerning your health that the Doctor should be told about? ❑ **Yes** ❑ **No** ***(if so, describe)***

Do you wish to speak to the doctor privately about anything?

❑ **Yes** ❑ **No**

Is there a **FAMILY HISTORY** of:

301 **Cancer:** ❑ Yes ❑ No
302 **Diabetes:** ❑ Yes ❑ No
303 **Heart Disease:** ❑ Yes ❑ No
304 **Anesthetic Problems:** ❑ Yes ❑ No

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Tel.(_____) _____

Bus. Tel.(_____) _____

IS THIS VISIT RELATED TO AN ACCIDENT? **Automobile:** ❑ Yes ❑ No
Work Related: ❑ Yes ❑ No
Other: ❑ Yes ❑ No

Date of Injury _____

Insurance company handling this claim _____

Claim number _____

Name of Attorney / Adjustor _____

Telephone Number (_____) _____

THIS SECTION (401-404) IS FOR WOMEN ONLY, MEN CONTINUE BELOW. WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.

401 Is there a possibility of pregnancy? ❑ Yes ❑ No

402 Expected delivery date _____

403 Are you nursing? ❑ Yes ❑ No

404 Are you taking birth control pills? ❑ Yes ❑ No

Women Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.*

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

X **Date** X **Signature of patient** *(Parent or Guardian if minor)*

Witness: X

Doctor: X

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT

NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non-essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are “potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection.” The ADA also recommends that urgent dental care which “focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments” be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

Signature Date

_____

Witness

COVID-19 PANDEMIC PATIENT DISCLOSURES

_____ _____

Patient's Name Date of Birth

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19, also known as "Coronavirus," pandemic.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that such disclosures may impact treatment decisions.

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. These symptoms may appear 2-14 days after exposure to the virus. It is important that you disclose any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Pre-Appointment		In-Office	
	Yes	No	Yes	No
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐	☐	☐
Have you tested positive for COVID-19?	☐	☐	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐	☐	☐
Have you traveled outside the United States or to high-risk areas in the past 14 days?	☐	☐	☐	☐
Do you have a fever or above normal temperature?	☐	☐	☐	☐
Have you taken any fever-reducing medications, including: ibuprofen (Advil, Motrin or other), acetaminophen (Tylenol or other), naproxen (Aleve or other) or aspirin in the last 14 days and, if yes, for what reason? _____	☐	☐	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐	☐	☐
Do you have a cough?	☐	☐	☐	☐
Do you have a runny nose?	☐	☐	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐	☐	☐
Do you have a sore throat?	☐	☐	☐	☐
Have you experienced chills or repeated shaking with chills?	☐	☐	☐	☐
Do you have muscle pain?	☐	☐	☐	☐
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐	☐	☐	☐
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐	☐	☐	☐
Do you otherwise feel unwell?	☐	☐	☐	☐

COVID-19 PANDEMIC PATIENT DISCLOSURES

_____ _____

Patient's Name Date of Birth

I fully understand and acknowledge the above information, risks and cautions and have disclosed to my provider any other conditions in my health history. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature (optional) Date

Revised May 15, 2020