

COVID-19 QUESTIONNAIRE

PATIENT DISCLOSURES:

Patient Name _____

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

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 we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced shortness of breath or had trouble breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry cough?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a runny nose?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or had a reduction in your sense of smell or taste?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a sore throat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in contact with someone who has tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been tested for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
If so, have you tested <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Awaiting Results		
Have you traveled outside the United States by air or cruise ship in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled within the United States by air, bus or train within the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

X _____ **X** _____ **X** _____
Signature of patient (Parent or Guardian if Minor) Witness Date

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. 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 can create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

Patient Acknowledgement

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.

X _____ **X** _____ **X** _____
Signature of patient (Parent or Guardian if Minor) Doctor Date

Welcome to our Practice

Today's Date 07/14/2020

PATIENT INFORMATION:

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____
Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? Yes No
Referred By _____ FIRST NAME _____ LAST NAME _____ Has a family member ever been a patient of our practice? Yes No
Dentist _____ FIRST NAME _____ LAST NAME _____ Orthodontist _____ FIRST NAME _____ LAST NAME _____
Medical Dr. _____ FIRST NAME _____ LAST NAME _____ Preferred Pharmacy _____ Tel. (_____) _____
Driver's Lic.# _____ Nearest relative not living with you _____ FIRST NAME _____ LAST NAME _____ Tel. (_____) _____
Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: Cash Check Credit Card
In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

Self (If self, skip this section) Spouse Father Mother Other _____
Name _____ FIRST NAME _____ LAST NAME _____ S.S.# _____ Birth Date _____ Age _____
Tel. (_____) _____ Cell. (_____) _____ E-mail _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Driver's Lic.# _____ Employer _____ Bus. Tel. (_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

Name _____ FIRST NAME _____ LAST NAME _____ Relation _____ S.S.# _____ Birth Date _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION:

Student: Full Time Part Time Not School Name and Address _____ SCHOOL NAME _____ ADDRESS _____
Marital Status: . Married Divorced Widowed Single Legally Separated _____ CITY _____ STATE _____ ZIP _____
Employed: Full Time Part Time Retired Not Do you belong to a PPO or HMO? Yes No

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____
Bus. Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party _____ FIRST NAME _____ LAST NAME _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____
Bus. Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party _____ FIRST NAME _____ LAST NAME _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____
Bus. Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party _____ FIRST NAME _____ LAST NAME _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____
Bus. Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party _____ FIRST NAME _____ LAST NAME _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

HEALTH HISTORY:

Patient Name _____

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications 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 |
|--|--------------------------|--------------------------|
| 1. Height _____ Weight _____ Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you under the care of a physician? Date of last visit _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, for what are you being treated? _____ | | |
| 4. Have you had any illness, operation or been hospitalized in the past five years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, describe _____ | | |
| 5. Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, describe where _____ | | |
| 6. Do you have a prosthetic joint / implant? If so, describe where _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a heart valve replacement or vascular graft? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had general anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you, or a family member, had any unusual or serious reactions to general anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke or vape? If so, how much a day _____			
30. Do you use chewing tobacco?			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			
37. Gallbladder trouble?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Fainting spells?			
39. Convulsions / epilepsy?			
40. Stroke?			
41. Thyroid trouble?			
42. Diabetes?			
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Stomach ulcer / acid reflux?			
51. Contagious diseases?			
52. Sexually transmitted diseases?			
53. Problems with immune system? Possibly from medication / surgery, etc.			
54. Delay in healing?			
55. A tumor or growth?			
56. Cancer / radiation therapy / chemotherapy?			
57. Chronic fatigue / night sweats?			
58. Are you on a diet?			
59. A history of alcohol abuse?			
60. A history of marijuana or other drug use?			
61. Contact lenses?			
62. Eye disease / glaucoma?			
63. Mental health problems / anxiety / depression?			
64. A removable dental appliance?			
65. Pain or clicking of jaws when eating?			

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 doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **X** _____ **X** _____ **X** _____
Signature of patient (Parent or Guardian if Minor) **Date** **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your 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.

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

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.

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

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 to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment

I permit the office to communicate with me via text message on my cell phone.

X _____ **X** _____ **X** _____
Signature of patient (Parent or Guardian if Minor) **Doctor** **Date**

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.

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