

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT 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.

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:		
X	x	X
Signature of patient (Parent or Guardian if Minor)	Doctor	Date

Welcome to our Practice

PATIENT INFORMATION:	Today's Date 04/23/2020
□ Mr. □ Mrs. □ Ms. □ Dr. First NameM.I	Last Name
Sex: Male Female Birth DateAgeSoc. Sec. #	
Street AptCity_	
Home Tel.() Cell.()	
Referred By FIRST NAME Has	
Dentist Orthodontist Orthodontist	RST NAME LAST NAME
Medical Dr. Preferred Phar	rmacyTel.()
Driver's Lic.#Nearest relative not living with you FIRST N.	
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	Birth Date Age
Tel.()	ail
Street AptCity_	StateZip
Driver's Lic.#Employer	Bus. Tel.()
SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFER	ENT FROM ABOVE)
Name Relation	S.S.#Birth Date
StreetAptCity_	State Zip
Tel. ()Employer	Bus. Tel.()
INSURANCE INFORMATION:	
Student: D Full Time D Part Time Not	and Address
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HEALTH HISTORY:

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To our p	Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. He may have, or medications that you may be taking, could have an important interrelationship with the care that you will be 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.	HeightWeightAre you in good health?						
2.	Have there been any changes in your general health in the past year?						
3.	Are you under the care of a physician?	_ 🗆					
	If so, for what are you being treated?	_					
4.	Have you had any illness, operation or been hospitalized in the past five years?						
	If so, describe	_					
5. Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?							
	If so, describe where	_					
6.	Do you have a prosthetic joint / implant?	_ 🗅					
7.	7. Have you had a heart valve replacement or vascular graft?						
8.	Have you ever had general anesthesia?						

HAV	YE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
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?		

HAV	E YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
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?		

WO	MEN ONLY: (QUESTIONS 66-69)							
	66. Is there a possibility of pregnancy? 67. Expected delivery date?		Yes	No	68. Are you nursing?	Yes □ □	No	
		veness of	birth control p	oills. Cons	ult your physician / gynecologist for assistance regarding other methods of		_	
ADE	VOLUNION TAKING	VEC NO	NOTE	c	ADE VOILALIERCIC TO OR HAD A REACTION TO. VEC. NO	NO	TEC	
		YES NO	NOTES	5	ARE YOU ALLERGIC TO, OR HAD A REACTION TO: YES NO	NO	E9	
	Any kind of medication, drug, pills?		_		78. Local anesthetic (numbing meds.)? 79. Penicillin?			
	Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba,				80. Other antibiotics?			
	Aggrenox, Xarelto, Eliquis, Fish oil)?							
72. l	2. Have you ever taken diet pills?				81. Sulfa drugs?			
	Any natural product, herbal				82. Sodium pentothal / Valium /other tranquilizers?			
	supplement or homeopathic remedy?				83. Aspirin?			
 Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphos- 					84. Amoxicillin?			
ŗ	phonates such as Prolia, Fosamax, Boniva,				85. Codeine or other narcotics?			
	Actonel, IV-Zometa, Aredia, Reclast, Xgeva, or Evista in the past 12 years?				86. Latex?			
	ranquilizers, sleeping pills, anti-depressant	s and/or	narcotics	nn a	87. Soy?			
	egular basis? If so, please list:	3, 4114/01	narconcs c) i i d	88. Eggs / yolk?			
					89. Sulfites?			
	f you are under the care of a physician for p				90. Do you have any known allergies?			
recovering from drug addiction please select the medication you are currently taking: Methadone Suboxone Oxycodone Fentanyl Other				91. Please list any allergies other than drug allergies:				
	reating doctor:							
77. F	Please list any medications you are currentl	y taking:	1					
	Medication	Dosage	Frequer	ncy				
				92. Please list any other medication or antibiotic you are a	llergic 1	to:		
				Medication / Antibiotic Name				
					Is there a family history of:			
					☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthes	ia prob	lems	
Is this visit related to an accident? Yes No								
If you are having surgery today , have you had anything to eat or drink in the last 6 (six) hours? \square Yes \square No			ink	If Yes, what type of accident? ☐ Automobile ☐ Work related ☐ Other Date of injury				
Who is driving you home?					Insurance company handling the claim			
Is there any condition concerning your health that the Doctor should					Claim number			
be told about? ☐ Yes ☐ No – If Yes, describe					Name of attorney / adjustor			
Do you wish to speak to the Dr. privately about anything? ☐ Yes ☐ No					Telephone number ()			

I certify that I have read and I understand the questions absatisfaction. I will not hold my doctor, or any other member						
X X	X		x			
Signature of patient (Parent or Guardian if Minor)	Date Review	red by	Date			
	FEES & PAYMENTS	 }				
We make every effort to keep down the cost of your carmanager depending upon special circumstances. An estimation and dental and/or medical insurance we will be glad to fill our medical insurance will be g	ate of the charge for any procedure or	r surgery you may require will	be given to you upon request. If you have			
Please remember that insurance is considered a method of fixed allowances for certain procedures and others pay a other balance not paid for by your insurance company.	percentage of the charge. It is your	responsibility to pay any d	leductible amount, co-insurance or any			
X			x			
Signature of patient (Parent or Guardian if Minor)			Date			
This signature on file is my authorization for the release of otherwise payable to me. \pmb{X}	information necessary to process my		ment to this doctor named of the benefits			
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						
$\hfill \Box$ I permit the office to communicate with me via text meaning the second sec	essage on my cell phone.					
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			