COVID-19 - PATIENT DISCLOSURES

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 weakened 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
Have you recently lost or had a reduction in your sense of smell?		
Do you have a sore throat?		
Have you been in contact with someone who has tested positive for COVID-19?		
Do you have a runny nose?		
Have you tested positive for COVID-19?		
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Have you been tested for COVID-19 and are awaiting results?		
Have you traveled outside of the US in the past 14 days? If so, where? _____		

I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including a dental office, and I have been informed that my dentist desires to protect the safety of the dental office and the patients, staff and other individuals who come upon the premises.

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.

_____ _____ _____

Signature of Patient or Legal Guardian **Relationship** **Date**

HEALTH HISTORY

Patient Name:_____Birth Date: _____/_____/_____ Age: _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?

   If YES, why?_____

4. Yes No Are you being treated by a physician now? For what?_____

   Date of last medical exam: _____

   Date of last Dental exam: _____

5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	50.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list: _____

VI. WOMEN ONLY:

65.	Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

68. If you have allergies to drugs, foods, medications, latex - please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____ _____

Signature of Patient or Legal Guardian **Relationship** **Date**

PATIENT INFORMATION

Name _____ Sex M F Birth date _____Age _____
Last Name First Name Middle Initial

Home Address:_____
Number and Street Address City State Zip Code

Home Phone_____ Cell Phone_____

Social Security #:_____E-mail address:_____

Marital Status: Single __Married__Widowed__ Separated__ Referred by_____

Emergency Contact Information

Name: _____

Relationship: _____ Phone: (_____)_____

DENTAL HISTORY

Reason for Today's Visit: _____

Last time you went to the dentist :_____Date of Last Dental X-rays:_____

Check (x) if you have had problems with any of the following:

Sensitivity to hot	Sensitivity to cold	Sensitivity when biting	Sores or growths in your mouth
Grinding Teeth	Loose teeth	Broken Teeth/fillings	History of Gum Disease
Bad Breath	Food caught between teeth		Clicking and popping of jaw

PRIMARY INSURANCE

Subscriber Name: _____Relation to Patient:_____

Birth date: _____ID#/SS#: _____ Email: _____

Address (if different from patient): _____Phone:_____

Employed By:_____Occupation:_____

Employer Address:_____ Employer Phone :_____
Number and Street Address City State Zip

Insurance Company:_____ Insurance Phone:_____

Group #_____Subscriber #/ID#_____

SECONDARY INSURANCE (As a courtesy we can submit claims for you to your secondary insurance. You still have to render your co-payment and deductible if any from your Primary Insurance)

I agree that my Protected Health Information (PHI) may be shared with the following people:

_____ _____

We are required by law to maintain the privacy and security of your Protected Health Information (PHI). We are also required to provide you with our notice of privacy practices which describes our legal responsibilities and your rights regarding the use and disclosure of your PHI. Your signature below is an acknowledgement that you have received our notice of privacy practices. (If you wish, please ask for your copy).

_____ _____ _____

Signature of Patient or Legal Guardian **Relationship** **Date**

GENERAL CONSENT

1. I authorize The Attentive Dentist, LLC's staff to take x-rays, study models, photographs, head exam neck, and soft tissue of the mouth to detect oral cancer and infections. I also authorize them to use any other diagnostic help to give appropriate dental care according to my needs.
2. I authorize Dr. Patino to complete the recommended treatment as long as I, the patient or guardian, agree and to use the appropriate medication and the indicated therapy. I understand that the use of anesthetics may have risks. I authorize Dr. Patino to choose and use any assistance necessary to provide the recommended treatment.
3. I understand that I am responsible to pay costs for dental services provided in this office for myself or my dependents. Charges are canceled the same day that the services are given. If the payments are not received when the treatment is finished, I understand that there will be a 1.5% charge (18% interest) that will be added to my account and collection charges. The account will be referred to collection services when there is a balance over $100 aged six months. I agree to cover the expenses for processes of legal action due to collection charges.
4. I understand that it is my responsibility to let The Attentive Dentist, LLC know of any change in the information that I have given previously.
5. I understand that there is a cancellation fee of $50.00 will be charged if I miss a reserved appointment or if I do not cancel it with 24 hours in advance.

_____ _____ _____

Signature of Patient or Legal Guardian **Relationship** **Date**

INSURANCE CLAIM POLICY

The Attentive Dentist, LLC is not an entity of your dental insurance company. It is the patient's responsibility to know the details of their dental insurance policy. Any portion of the patient's account not covered by dental insurance is the responsibility of the patient. With regards to major dental treatment (i.e. Crown, Bridges, Prosthetics, Implants), the estimated portion of the account not covered by the patient's dental insurance is due at the time of treatment. This office cannot finance any portion of dental treatment that is not covered by dental insurance. If you have any questions, please ask the office manager at the reception desk.

FINANCIAL AGREEMENT

I certify that I, and /or have insurance coverage with _____and assign directly to The Attentive Dentist, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The Attentive Dentist, LLC may use my health care information and may disclose such information to the above name Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____ _____

Signature of Patient or Legal Guardian **Relationship** **Date**