COVID-19 Emergency Treatment Consent Form

I,_____(the patient), consent to receive emergency treatment from Silicon Valley Endododontics and Microsurgery during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that under the CDC and ADA guidelines, do not recommend proceeding with any treatment that is non-essential at this time.

I understand that the treatment I am receiving is an emergency because of the underlying infection, pain, or conditions that limit my normal day-to-day activities. I confirm I am seeking treatment for a condition that meets these criteria._____**(Initial)**

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread.

I understand that the symptoms listed below are representative of COVID-19:

- Fever, Dry Cough, Shortness of Breath, Temperature, Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that I do not display or currently have any of the symptoms that are representative of COVID-19, which are outlined above:_____**(Initial)**

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days**.____(Initial)**

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days._____**(Initial)**

Patient Name:_____Date: _____

Patient/Guardian Signature:_____

For Practice Use:
Doctor Signature:_____Date: _____

Patient Personal Information

Patient Name: _____Preferred to be called _____

Mailing Address: _____City: _____

State:_____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Best Method to Contact: _____

Social Security #: _____ Birthdate: _____ Sex: M F Binary
(SS needed for insurance claims)

Employer: _____ Occupation: _____

Work Company or Address: _____

If patient is minor, who is legally responsible? _____

In case of emergency, whom can we contact? _____

General (or Referring) Dentist:_____ Physician: _____

Dental Insurance
(For proper billing, all insurance information is needed)
For financial questions, please refer to Financial Policy

Primary Coverage
Insured's/Subscriber's Name: _____ Social Security #: _____

Name of Insurance Company_____ Birthdate_____

Insured ID #_____ Group #_____

Secondary Coverage
Insured's/Subscriber's Name: _____ Social Security #: _____

Name of Insurance Company_____ Birthdate_____

Insured ID #_____ Group #_____

Acknowledgement of Receipt of Notice of Privacy Practice
(You may refuse to sign this acknowledgement)

I, _____, have received a copy of this office's notice of privacy practice

_____ _____

(Please print name) (Signature) (Date)

Tell Us About Your Symptoms

1. Are you experiencing any pain at this time? Yes __ No __
   If not, please go to Question 6.
2. If yes, can you locate the tooth that is causing the pain? Yes __ No __

3. When did you first notice the symptoms? _____
   Have you ever had this type of pain before?
4. Did your symptoms occur suddenly or gradually? _____
5. Please check the frequency and quality of the discomfort, and the number that most closely reflects the intensity of your pain:

LEVEL OF INTENSITY (On a scale of 1 = mild to 10 = severe)
1———2------3-----4------5------6-----7------8------9-----10

FREQUENCY	QUALITY
__ Constant	__ Sharp
__ Intermittent	__ Dull
__ Momentary	__ Throbbing
__ Occasional	

Is there anything you can do to relieve the pain? Yes __ No __
If yes, what? _____

Is there anything you can do to cause the pain to increase? Yes __ No __
If yes, what? _____

When eating or drinking, is your tooth sensitive to: Heat__ Cold __ Sweets __
If so, does it linger? Yes __ No __

Does your tooth hurt when you **bite** down or chew? Yes __ No __

Does it hurt if you press the gum tissue around this tooth? Yes __ No __

Does a change in **posture** (lying down or bending over) cause your tooth to hurt? Yes __ No __

6. Do you grind or **clench** your teeth? Yes __ No __
   If yes, do you wear a night guard? Yes __ No __

7. Has a **restoration** (filling or crown) been placed on this tooth **recently**? Yes __ No __

8. Prior to this appointment, has root canal therapy been initiated on this tooth? Yes __ No __

9. Is there anything else we should know about your teeth, gums, or sinuses that would assist us in our diagnosis? _____

Signed: Patient or Parent _____ Date _____

Confidential Health History

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexual transmitted disease
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?
(Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or other sedatives	Yes / No	Codeine or other narcotics
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Anti-Depressants	Yes / No	Herbal Supplements		

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name: _____ **Relationship**: _____ **Phone Number**: _____

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____
Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

Notice of Privacy Practices

Patient Responsibilities

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment Cash, Check, and Credit Cards.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. Our practice is a contracted provider with Cigna, Delta Dental, Metlife, Guardian, Anthem Blue Cross, Liberty and Principal Financial.

- If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

- If we are <u>not</u> a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor 's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $__50_ or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is 15 minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $_25_ or deposit to reserve the appointment time again, may be required.

Patient Authorizations

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____ (initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (circle one) _____ (initial)

Patient Communication

Voice Messages: I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication. _____ (initial)

Email: Except for appointment reminders, we use secure methods to electronically communicate with our patients. **Unencrypted email is not a secure form of communication.** There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify your email address.

_____ *I prefer to receive information via the practice's secure communication methods. My email address is _____.*

_____ *I consent and accept the risk in receiving information via unencrypted email. I understand I can withdraw my consent at any time. My email address is _____.*

_____ *I consent to receiving appointment reminders via unencrypted email. I understand the minimum necessary information is used in these reminders. I understand I can withdraw my consent at any time. My email address is _____.*

_____ *I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.*

Cellphone:

☐ I consent to the dental practice using my cellphone number to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time. My cellphone number is (include area code) _____ _____ (initial)

Patient Acknowledgements

I hereby acknowledge that a copy of this practice'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. _____ (initial)

I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)