Woodlands Dental Specialists

~ Endodontics ~

COVID-19 Treatment Consent Form

I,____(Patient's Name), consent to receive emergency treatment from **Woodlands Dental Specialists** 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 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.

MORE ON BACK

1011 Medical Plaza Dr., Suite 210
The Woodlands, TX 77380
Phone (281)893-1060 Fax (281)893-6807

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:___________________________________

Patient/Guardian Signature:____

Date:_____________________

For Practice Use:

Doctor Signature:____

Date:_____________________

Woodlands Dental Specialists

~ Endodontics ~

NAME____ Referred to us by______________________________

Parent/Guardian if minor____

Date of birth_____ _____ _________ ____Single ____Married ____Minor *(under 18)*

Address____ Apt# __________ Home ph____________________

City____________________________ State_____ Zip__________ Cell ph _______ ______________________

____Male ____Female SS# _________ ________ _________ Email Address______________________________________

Emergency Contact ____________________ Relationship _________________ Emergency ph ______ ______________

Pharmacy Name _____________________________ Pharmacy Number____________________

Please complete all items below for Dental Insurance processing

DENTAL INSURANCE ____None ____Dental Plan PPO

Policy holder____ Do you have your dental ID card? _____

Date of Birth_____ _____ ________ Are you covered under a 2nd plan? _____

Policy holder SS## __________ ______ _________ Patient relationship to policy holder ___Self ___Spouse ___Dependent

Policy holder Ins. ID#______________________

Policy holder employer____

Insurance company____ Insurance company ph______ ______________

Group #___________________

INSURANCE AGREEMENT

We will gladly file a claim for your services on your behalf as a courtesy and accept assignment of benefit (payment to be sent to the practice) from your insurance company to supplement out of pocket expenses. However, it is important to understand insurance is a contract between you, your employer, and the insurance company. We are not a participant in some of these contracts making our practice **out of network**.
Also, it is your responsibility to notify us of any changes or cancellations in your insurance prior to the start of your appointment.
We recommend treatment based on individual needs and not insurance benefits. We provide you an **estimate** of insurance benefits based on the information available. We **cannot guarantee** the amount your insurance will pay/cover due to many limitations and exclusions in your policy. **Any balance not paid by your insurance is still your responsibility.** If you do not approve of this policy, we are happy to assist you in filing your own insurance claim.

☐ **I understand and acknowledge Woodlands Dental Specialists is out of network with some insurance companies and cannot guarantee the amount my insurance will pay/cover due to many limitations and exclusions in my policy.**

Signature: ____ Date: ______________

Woodlands Dental Specialists

~ Endodontics ~

PATIENT CANCELLATION POLICY

Please understand that when we schedule your appointment, we are reserving time for your particular needs. We reserve a room for you and your records and insurance is verified and prepared. We kindly ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved time to another patient who is in need of it. Please call the office if you need to cancel or reschedule an appointment.

We understand that emergencies happen, and will work with any patient that may need to move an appointment. Thank you for your understanding and in order to provide the best experience for all of our patients, we ask that you arrive at your scheduled appointment time.

☐ **I understand that there is a $40 charge (per appointment) if I cancel without providing a 24 hours notice or if I do not show for my appointment. The payment must be made in order to schedule my next appointment.**

Printed Patient Name(s): ____

Signature: ____ Date: ________________

MEDICAL HISTORY for ENDODONTIC PATIENTS (Root Canal)

ANSWER ALL QUESTIONS. CIRCLE Y (Yes) or N (No)

PRESENT OR PAST CONDITION

Congestive heart failure (CHF) .... Y N
Heart disease, arteriosclerosis .... Y N
Angina, chest pain .... Y N
Previous heart attack .... Y N
Heart surgery .... Y N
Congenital heart defect .... Y N
Heart valve replacement .... Y N
Pacemaker, palpitations .... Y N
High blood pressure .... Y N
Low blood pressure .... Y N
Rheumatic fever, rheumatic heart problems ...... Y N
Heart murmur .... Y N
Mitral valve prolapse, other valve problems ...... Y N
Previous stroke, CVA, or TIA .... Y N
Epilepsy, seizures, convulsions .... Y N
Fainting spells, dizzy spells .... Y N
Joint, knee, hip replacement .... Y N
Kidney disease .... Y N
Hepatitis/liver disease Type A B C .... Y N
Thyroid problems, high or low .... Y N
Diabetes in self, mother, father .... Y N
Anemia, iron deficiency, sickle cell .... Y N
Bleeding disorder, hemophilia, bruising .... Y N
Leukemia or other cancer .... Y N
Chemotherapy, radiation therapy .... Y N
HIV, AIDS .... Y N
STD (sexually transmitted disease) .... Y N
Alcohol dependency .... Y N
Prescription drug dependency .... Y N
Tuberculosis .... Y N
Tobacco use of any kind .... Y N
Asthma, bronchitis, chronic cough .... Y N
COPD, breathing prob, emphysema, pneumonia Y N
Hay fever, seasonal allergy .... Y N
Sinus or nasal problems .... Y N
Allergies, rash, hives, throat swelling .... Y N
Arthritis or inflammatory rheumatism .... Y N
Stomach ulcers, colitis, IBS .... Y N
Mouth ulcers .... Y N
Glaucoma, eye diseases .... Y N
Jaw surgery .... Y N
Neuralgia, neuritis in head/neck .... Y N
Osteoporosis, osteopenia .... Y N
Depressed immune system .... Y N
Women: Are you pregnant? Nursing? .... Y N

HAVE YOU USED THE FOLLOWING IN PAST 48 HOURS?

Cocaine .... Y N
Amphetamines, diet pills .... Y N
Ecstasy, Methamphetamines .... Y N
Herbal remedies or herbal stimulants .... Y N
Energy boosters containing ephedrine .... Y N
Alcohol, tranquilizers, sedatives .... Y N

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:

____
____

ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? _____

Name____________________________________
Specialty__________________________________
Conditions treated____________________________
____
____

Recent surgery or hospital stay?________________________
____

May we request medical information related to your treatment?

CURRENT MEDICATIONS YOU'RE TAKING (List below)

Antibiotics ____________________________ Y N
Pain medication__________________________ Y N
Oral steroids such as Prednisone_____________ Y N
Aspirin therapy, Aleve, Motrin ______________ Y N
Blood thinners __________________________ Y N
Blood pressure meds______________________ Y N
Nitroglycerin____________________________ Y N
Digitalis, Inderal________________________ Y N
Cholesterol lowering _____________________ Y N
Anti-depressants/tranquilizers ______________ Y N
Insulin, diabetes ________________________ Y N
Antihistamines __________________________ Y N
Birth control pills _______________________ Y N
Asthma meds or inhalers __________________ Y N
Epilepsy/seizure meds_____________________ Y N
Thyroid meds ___________________________ Y N
Fosamax, Actonel, Boniva or other osteoporosis meds … Y N
Zometa, Reclast, Aredia, Prolia or other IV cancer meds Y N
Other meds or herbal remedies .... Y N
____

HAVE YOU HAD AN ADVERSE REACTION TO:

Dental anesthetic (Novocain) .... Y N
Latex or Rubber .... Y N
Aspirin or Ibuprophen .... Y N
Penicillin, Cephalosporin, or other antibiotic .... Y N
Codeine, Vicodin (Hydrocodone)................................ Y N
Sedatives, tranquilizers, barbiturates .... Y N
Sulfa drugs .... Y N
Iodine, metals, chemicals .... Y N
Foods .... Y N
Other drug reactions __________________________

DO YOU PREFER NITROUS OXIDE/OXYGEN (laughing gas) FOR TREATMENT? ____Yes ____No (There is a fee for this service)

NAME ____________________________________

Date of Birth _____/_____/ ________ ___Male ___Female

Referred By Dr.________________________________

____________________________ ____________
Patient Signature **Date**
(Guardian/parent sign for patient under 18)

For Office Use:
Reviewed by ____________________ *Date*__________
*Updated by*_____________________ *Date*__________

Endodontics Informed Consent for Treatment
Woodlands Dental Specialists

This is my consent to perform any necessary dental procedures as indicated by my examination which may include, but are not limited to: diagnostic procedures, treatment procedures, use of local anesthetics and sedation with Nitrous Oxide/Oxygen. Every effort has been made to reduce the risks associated with treatment.

_____ I understand that although root canal therapy has a high degree of success, it is a biological procedure and has no guarantee of success. Occasionally, a tooth which has been treated by root canal therapy may need re-treatment, surgery, or even extraction.
____ I understand that re-treatment cases or mid-treatment cases (started by another dentist) are more difficult, more prone to complications, and may have a lower success rate.
____ I understand that there are alternatives to root canal therapy or re-treatment root canal therapy which include: no treatment at all, extraction of the tooth with no replacement or replacement with a bridge, partial denture or implant.
____ I understand that the permanent restoration (filling or crown) will be done by my general dentist following root canal treatment. Failure to restore the tooth properly could result in fracturing and loss of the tooth. Follow-up exams and x-rays may be needed to follow the healing of treated teeth.
____ I understand that the injection of local anesthetics may result in soreness, swelling, bruising, and occasionally temporary or permanent numbness of the area injected. For some patients, medications in the injection may cause an increase in heart rate, irregularities in heart rate, or difficulty breathing.
____ I understand that there are certain inherent and potential risks in any treatment procedure. These include:

- *Pain, swelling, fever or infection may be present after treatment.*
- *Limited jaw opening for treatment may result in short term muscle or jaw pain.*
- *Fracture of existing tooth structure, fillings, crowns, or bridges may occur during treatment.*
- *Calcified, curved canals may complicate treatment resulting in the root canals being blocked, ledged, or perforated; or the possibility of broken instruments.*
- *Slight overfills or underfills of sealer or filling material may occur.*
- *Existing multiple pain patterns may require initial treatment plus additional treatment to alleviate pain symptoms.*
- *Cracked tooth syndrome: Undetectable by x-ray examination, the majority of cracks occur in the crown portion of the tooth and can be saved with root canal therapy and full crown restoration. Cracks of the root portion of the tooth can affect healing and may result in continued chewing pain and eventual extraction.*

____ I understand that I will have an opportunity to ask the endodontist questions and have them answered to my satisfaction prior to treatment.

Signed by Patient, Parent or Agent: ________________________________ Date ____________
Print Name ____

Nitrous Oxide Consent

I understand that nitrous oxide is an odorless, non-absorbed gas, that when used by inhalation in the dental setting can reduce gag reflexes, reduce anxiety levels and help in comfort during dental procedures and appointments. If I have taken any prescription sedative or drugs, I will let the doctor know, as some sedatives are contraindicated with nitrous oxide use.

Nitrous oxide can make you feel as if you had a couple glasses of wine but you should return to normal alertness quickly following the procedure. Some patients do not like this feeling or feel claustrophobic under the nose piece. The nitrous can be stopped at any time however we encourage you to breathe pure oxygen for 5-10 minutes to reduce the chances of an intense headache or fatigue following the appointment. These are all normal risks of nitrous oxide sedation for dentistry.

☐ I have read the above pre and post-operative information, and agree to the administration of nitrous oxide during treatment ____________________________________. (patient/ guardian signature)

Woodlands Dental Specialists

Consent for Use and Disclosure of Health Information

Health Insurance Portability and Accountability Act

Please read the following carefully.

Purpose of Consent

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

1011 Medical Plaza Dr. Suite 210 281.893.1060 Office 281.893.6807 Fax

Consent

I, ____**(please print)**, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: X____ **Date: X**__________________

If a personal representative on behalf of the patient is signing this consent, please complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

Right to Revoke

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that **we may decline to treat or continue treating you if you revoke this Consent.**

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. **I also understand that you may decline to treat or continue to treat me after I have revoked my consent.**

Signature: ____ Date: ____________________

If a personal representative on behalf of the patient is signing this revocation of consent, please complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____