WELCOME TO OUR PRACTICE

Today's Date _____

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Social Security Number _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ E-mail _____

Did you find our practice online? ❑ Yes ❑ No Referred By _____ (FIRST NAME) _____ (LAST NAME)

Have you ever been a patient of our practice? ❑ Yes ❑ No 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 ❑ Widow ❑ 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)

STOP! DETACH THIS TOP SHEET ONLY, AND BRING IT TO THE FRONT DESK BEFORE PROCEEDING

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily [illegible] the area in and around your mouth, your mouth is [illegible] 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?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	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? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you ever had general anesthesia?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

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. Acid reflux?			
51. Stomach / GI troubles / ulcers / IBS / colitis?			
52. Contagious diseases?			
53. Sexually transmitted diseases?			
54. Problems with immune system? Possibly from medication / surgery, etc.			
55. Delay in healing?			
56. A tumor or growth?			
57. Cancer / radiation therapy / chemotherapy?			
58. Chronic fatigue / night sweats?			
59. Are you on a diet?			
60. A history of alcohol abuse?			
61. A history of marijuana or other drug use?			
62. Contact lenses?			
63. Eye disease / glaucoma?			
64. Mental health problems / anxiety / depression?			
65. A removable dental appliance?			
66. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 67–70)*

67. Is there a possibility of pregnancy? ❑ Yes ❑ No
68. Expected delivery date? _____
69. Are you nursing? ❑ Yes ❑ No
70. Are you taking birth control pills? ❑ Yes ❑ No

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

RE YOU NOW TAKING:	YES	NO	NOTES
. Any kind of medication, drug, pills?			
. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
. Have you ever taken diet pills?			
. Any natural product, herbal supplement or homeopathic remedy?			
. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?			

. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

. If you are under the care of a physician for pain management, or recovering from drug addiction, select the medication you are currently taking: ❑ Methadone ❑ Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other Treating doctor:

. Please list any medications you are currently taking:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

s there any condition concerning your health that the Doctor should e told about? ❑ Yes ❑ No – If Yes, describe

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

ARE YOU ALLERGIC TO OR HAD A REACTION TO:	YES	NO	NOTES
79. Local anesthetics (numbing meds.)?			
80. Penicillin?			
81. Other antibiotics?			
82. Sulfa drugs?			
83. Sodium pentothal / Valium /other tranquilizers?			
84. Aspirin?			
85. Amoxicillin?			
86. Codeine or other narcotics?			
87. Latex?			
88. Soy?			
89. Eggs / yolk?			
90. Sulfites?			
91. Do you have any known allergies?			

92. Please list any allergies other than drug allergies:

93. Please list any other medication or antibiotic you are allergic to:

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Name of attorney / adjustor _____

Tel (_____) _____ Claim number _____

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

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

Dr. Dante E. Gulino, Jr., DDS, MD, PC

Diplomate, American Board of Oral and Maxillofacial Surgery
Fellow, American Association of Oral and Maxillofacial Surgeons

495 Gold Star Highway, Suite 205
Groton, CT 06340
Phone: 860-449-1023 Fax: 860-326-5187

TREATMENT CONSENT FORM

This disclosure is meant to explain the potential risks that can be associated with oral surgeries and treatments. You have the right to be informed of your diagnosis and treatment in order to make a conscious decision as to whether you wish to undergo the procedure(s).

Cracking and *bruising* of the mouth, lip and jaw area are possible with extended opening and stretching of the mouth during oral procedures.

Swelling, Bruising, and ***Pain*** can occur with any surgery and can vary from patient to patient.

Trismus is a limited opening of the jaw due to inflammation and/or swelling of the muscles. This is most common with the removal of impacted wisdom teeth but is possible with any surgery.

Infection is also possible with any surgery and may require medication or further surgery if this does occur.

Drug Interactions such as nausea, rash, anaphylactic shock, diarrhea, and/or death can occur with any medications. We ask that you list any allergies to medications on your patient form as this information is critical to properly treating you.

Bleeding is usual with most surgeries and is normally controlled by following the instructions that are given to you. Significant bleeding can occur during and after the surgery but is not common.

Dry Socket causes significant pain in the jaw and ear due to loss of the blood clot and mostly occurs after the removal of lower wisdom teeth but is possible with any extraction.

Damage to other teeth or fillings is possible due to the close proximity of the teeth.

Bone spicules or ***sharp ridges*** on the socket may come through the gum after an extraction. This may require another office visit/surgery to remove the splinter or smooth the area.

Numbness, tingling, loss of taste or a *burning sensation* may occur on the lower lip, chin, teeth, tongue and/or gums depending on the location of the nerves underlying the lower teeth and tongue. In rare occasions, these symptoms may be permanent.

PLEASE READ AND SIGN CONSENT FORM CONTINUED ON NEXT PAGE

TREATMENT CONSENT FORM CONTINUED

TMJ Dysfunction occurs when the Temporomandibular Joint or jaw joint may not function properly after surgery and although unusual, may require treatment to regain normal function.

Breakage of the Jaw can occur on extremely rare occasions of oral treatment.

Sinus Involvement due to the close proximity of the roots of the teeth to the sinus area, especially the rear upper teeth, it is possible that an opening may develop from the mouth to the sinus cavity or that a root may displace into the sinus. This could cause a sinus infection for which medication maybe prescribed or the possibility that the opening could become permanent in which case additional surgery may be needed to repair the area.

Local and *General Anesthesia* both pose certain risks although these are uncommon. Local anesthesia can cause pain, swelling, bruising, infection, nerve damage, idiosyncratic and/or allergic reactions. General anesthesia may cause nausea, pain, swelling, inflammation of the vein, and/or bruising of the injection site. In rare cases there could be nerve damage to the arm, allergic or idiosyncratic drug interactions, pneumonia, heart attack, stroke, brain damage, and/or death.

I have been advised of and understand the possible risks as listed on this form that may occur with any oral surgery treatment and although good results are expected, the possibility of complications cannot be predetermined and therefore there are no guarantees as to the results of the procedure(s).

Patient Name: _____

I hereby authorize Dante E. Gulino, Jr. or other maxillofacial surgeon working with/for him to perform the following procedures: _____, and to administer anesthesia if necessary for my treatment. I understand that upon treatment the doctor may discover conditions that may require different or additional procedures than those that were planned. I authorize that these procedures be performed per the doctor's professional judgment.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Drs Stadelmann and Gulino Inc.

OUR FINANCIAL POLICY

P.1 of 2

Thank you for choosing us as your health care provider. We are committed to your treatment being as comfortable and successful as we can provide. Please understand that payment for services rendered is part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS
PRIOR ARRANGEMENTS HAVE BEEN MADE.
We accept CASH, CHECKS, VISA, MASTERCARD, AMEX and DISCOVER.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not part of that contract. You are responsible for the payment of services provided to you by the doctor. We will fill out the provider section of your claim form and submit the claim in your behalf at no charges. You must provide us with the appropriate information so that we may help you receive the maximum possible benefit from your coverage. Plans where we are participating, we agree to abide by the terms of our contract with the carrier. All co-pays and deductibles are due as services are rendered.

ESTABLISHED PATIENTS: May assign benefits to the office is a prior authorization and estimate of benefits has been received prior to treatment. A consultation and pre-determination is required prior to treatment. Please be aware that some, and perhaps all the services provided may not be covered under your insurance policy. It is important that you read and understand your policy. Your carrier can only provide specific answers as to the extent of coverage and reimbursement schedules.

PAYMENTS ARE ALWAYS DUE IN FULL FOR CONSULTATIONS.

USUAL AND CUSTOMARY RATE (UCR): Our practice is committed to providing the best treatment for our patients and we charge our patients what is reasonable and customary in our area for that level of service. Insurance carriers determine their own UCR, which may not match our office UCR. You are responsible for payment of our office fees regardless of the insurance company's arbitrary determination of UCR.

A notice of 5 business days is required for appointment cancellation.
Failure to comply will result in a $50.00 cancellation fee.
An office charge of $25.00 plus any bank fees charged to this office will be applied to all NSF check.

Thank you for understanding our financial policy. Please let us know if you have any question or concerns.

I have read and understand this financial policy. I understand my insurance as it relates to my treatment. This signature acts as my permanent insurance signature and allows the release of records to the insurance company and direct payment of insurance to the doctor's office. When applicable it is this office policy to charge a finance fee of 1.5% per month on balances outstanding more than 30 days (18% interest per year). If my account must be turned over to an attorney for collection, I will be held responsible for legal and collection fees. I understand the term and agree to abide by this policy.

DATE _____ SIGNATURE OF PATIENT or RESP. PARTY _____
If you are paying by check we require a valid driver's license # _____ State _____

te E. Gulino, Jr., DDS, MD, PC

85 Beach Street, Bldg B
Westerly, RI 02891
Office: 401-596-0337
Fax: 401-596-0349

495 Route 184, Suite 205
Groton, CT 06340
Office: 860-449-1023
Fax: 860-326-5187

P. 2. of 2.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being as comfortable and successful as we can provide. Please understand that payment for services rendered is also part of your treatment.

We require you to read and sign prior Financial Policy before any treatment is performed.
We accept Cash, Checks (with a valid driver's license on file) Visa, Mastercard, American Express, Discover and Care Credit.
In the event a balance is due after insurance payment, consent is given to use any previous credit /debit card on file to pay your balance off to zero balance.

DENTAL INSURANCE: Your dental insurance policy is a contract between you and your insurance company. *We are not part of that contract.*
You are responsible for payment of services provided to you by the doctor on the day services are rendered.
We will file your claim form and submit the claim in your behalf at no additional charge.
You must agree to provide us with the appropriate information asked by our dental staff so that we may help you receive the maximum possible benefit from your coverage. Please be aware that some and not all services will be covered under your insurance policy.
Plans where we are a participating provider, we agree to abide by the terms of our contract with the carrier. Dental plans that will only reimburse the subscriber directly will be filed on your behalf but payment in full will be paid prior to your dental treatment being performed by the doctor.

MEDICAL INSURANCE:
We do not participate with ANY medical plans! Therefore, you must pay on day of service in full as any claims submitted on your behalf depending on your treatment (if applicable) will be paid to us as an out-of-network provider.
Medicare does not cover tooth extractions. We will provide you with a statement if you wish to pursue reimbursement from your medical carrier. *All insurance companies quote us the terms of your policy, however payment is not guaranteed until your claim is actually submitted and reviewed by your insurance carrier's reviewers for determination of payment.*

Your estimate will be based on your insurance policy and any payment due after your insurance has paid a benefit to us on your behalf is due upon receipt of our statement to you.

CO-PAYS AND DEDUCTIBLES ARE DUE AT TIME SERVICES ARE RENDERED

We also reserve the right to assess a cancellation fee for broken appointments without a prior two (2) day notice. I have read and understand this financial policy. This signature acts as my permanent insurance signature and allows the release of records to the insurance company and direct payment of insurance to the doctor's office. It is also the office policy that a finance charge will be assessed of 1.5% per month on balances more than 30 days (18% interest per year). If your account is forwarded to our attorney for collection, any applicable legal and collection fees will also be your responsibility to pay. I understand this policy and I agree to abide by this policy.

Patient / Guardian Signature: _____ Date: _____

Dr. Dante E Gulino Jr.

Westerly 401-596-0337 * Groton 860-449-1023 *Cell 401-741-3224 drdantegulino@gmail.com

PRESCRIPTION MONITORING PROGRAM NOTIFICATION

BY SIGNING THIS FORM, YOU CONFIRM THAT YOU HAVE BEEN NOTIFIED IN WRITING, THAT IF YOU RECEIVE A PRESCRIPTION FOR A CONTROLLED SUBSTANCE (NARCOTIC DRUG) FROM EITHER OF OUR OFFICES AND FILL THAT PRESCRIPTION YOUR NAME AND PERSONAL INFORMATION WILL BE ENTERED INTO A SECURED STATE MAINTAINED PRESCRIPTION DRUG MONITORING (PMP) DATABASE. STATE LAWS REQUIRE PHARMACIES TO REPORT INFORMATION ABOUT CONTROLLED SUBSTANCE PRESCRIPTIONS FILLED TO THAT STATE'S PMP AND DEPARTMENT OF HEALTH.

THIS DATABASE IS USED TO PREVENT ABUSE OF CONTROLLED SUBSTANCES. THE DATA BASE IS FOR NARCOTIC BASED CONTROLLED PRESCRIPTIONS ONLY. SUCH AS BUT NOT LIMITED TO PAINKILLERS, MUSCLE RELAXANTS AND STEROIDS. IF YOU DO NOT WANT YOUR INFORMATION IN THE DATABASE, ASK FOR A NON-NARCOTIC DRUG PRESCRIPTION.

FOR MORE INFORMATION, PLEASE CONTACT YOUR STATE'S DEPARTMENT OF HEALTH.

I HAVE READ AND UNDERSTAND THIS NOTIFICATION.

_____

_____

DATE SIGNATURE OF PATIENT / GUARDIAN

IF THIS NOTIFICATION IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, PLEASE COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE NAME:_____

RELATIONSHIP TO PATIENT:_____

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT

NOTICE AND ACKNOWLEDGEMENT 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.

I have read and understand the information stated above:

_____ _____

Signature Date

_____

Witness

COVID-19 PANDEMIC - 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 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?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
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?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

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 Date

_____

Witness