Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have presented to the office today because you have an urgent dental condition which must be treated at this time and cannot be postponed until the current COVID-19 risk period abates. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	YES _____	NO _____
DO YOU HAVE A FEVER?	YES _____	NO _____
DO YOU HAVE ANY SHORTNESS OF BREATH?	YES _____	NO _____
DO YOU HAVE A DRY COUGH?	YES _____	NO _____
DO YOU HAVE A RUNNY NOSE?	YES _____	NO _____
DO YOU HAVE A SORE THROAT?	YES _____	NO _____
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	YES _____	NO _____
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	YES _____	NO _____
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	YES _____	NO _____
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	YES _____	NO _____
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?	YES _____	NO _____

IF SO, WHERE? _____

HEALTH HISTORY

For your safety, please complete this form accurately and completely. **This information is confidential**.

UPDATED 01/20

A) GENERAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Sex: □M □F

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ SSN#: (*needed for ins. claims*) _____

Mobile #: _____ Home #: _____ Work #: _____

Height: _____ Weight: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Do you currently have a primary care provider? (*doctor, phys. asst, nurse practitioner)*……. □ Yes □ No

Name: _____ Date of last visit: _____

Office Location: _____ Office Phone: _____

Have there been any changes in your general health within the past year?.....□ Yes □ No

Have you had a hospital stay, serious illness, or operation in the past 5 years?..... □ Yes □ No

If yes to any, please describe: _____

B) MEDICATIONS / SUPPLEMENTS □ None

List below, on back, or attach list.

Drug:	Dose:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

C) ALLERGIES/SENSITIVITIES □ None

□ Penicillin □ Sulfa
□ Latex □ Ibuprofen
□ Metals □ Other antibiotics
□ Other: _____
_____

D) PREMEDICATION FOR DENTAL VISITS *Have you had or do you have any of the following?:*

1. Total joint replacement (knee, hip, etc)..□ Yes □ No
2. Artificial (prosthetic) heart valve……□ Yes □ No
3. Infective endocarditis……□ Yes □ No
4. Heart transplant……□ Yes □ No
5. Congenital heart disease (CHD)……□ Yes □ No
6. Other condition requiring premedication:_____

E) BISPHOSPHONATES *Have you taken, do you take, or will you be taking any of the following?:*

1. Oral bisphosphonates such as alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for osteoporosis or other bone-related conditions?..... □ Yes □ No
2. Intravenous (IV) bisphosphonates such as Aredia® or Zometa® for cancer or other conditions?..... □ Yes □ No

F) FOR WOMEN ONLY

1. Are you pregnant, or do you think you might be pregnant?..... □ Yes □ No
2. Are you nursing/breastfeeding?..... □ Yes □ No
3. Are you taking birth control pills or hormone replacement?..... □ Yes □ No

HEALTH HISTORY, continued

G) MEDICAL INFORMATION *Do you currently have, or have a history of any of the following?:*

	Y	N		Y	N		Y	N
1. Cardiovascular disease	□	□	19. Autoimmune disease	□	□	37. Hepatitis	□	□
2. Chest pain/angina	□	□	20. Lupus	□	□	38. Other liver problem	□	□
3. Arteriosclerosis	□	□	21. Asthma	□	□	39. Epilepsy or seizures	□	□
4. Congestive heart failure	□	□	22. Bronchitis	□	□	40. Fainting	□	□
5. Damaged heart valves	□	□	23. Emphysema	□	□	41. Other neurologic problem	□	□
6. Heart attack	□	□	24. Sinus trouble	□	□	42. Sleep disorder	□	□
7. Heart murmur	□	□	25. Tuberculosis	□	□	43. Sleep apnea	□	□
8. Low blood pressure	□	□	26. Other respiratory problem	□	□	44. Mental health disorder	□	□
9. High blood pressure	□	□	27. Cancer/Chemo/Radiation	□	□	45. Depression	□	□
10. Pacemaker	□	□	28. Chronic pain	□	□	46. Drug/alcohol addiction	□	□
11. Other heart condition	□	□	29. Diabetes	□	□	47. Recurrent infections	□	□
12. Abnormal bleeding	□	□	30. Eating disorder	□	□	48. Kidney problem	□	□
13. Anemia	□	□	31. Gastrointestinal disease	□	□	49. Osteoporosis	□	□
14. Blood transfusion	□	□	32. GERD/acid reflux	□	□	50. Headaches/migraines	□	□
15. Hemophilia	□	□	33. Stomach ulcers	□	□	51. Venereal diseases (STDs)	□	□
16. AIDS or HIV	□	□	34. Thyroid problems	□	□	52. Visual impairment	□	□
17. Arthritis	□	□	35. Stroke	□	□	53. Hearing impairment	□	□
18. Rheumatoid arthritis	□	□	36. Glaucoma	□	□	54. Limited mobility	□	□

H) DENTAL INFORMATION

	Y	N		Y	N
1. Do your gums bleed easily?	□	□	10. Do you have head or neck pain?	□	□
2. Are your teeth sensitive to hot or cold?	□	□	11. Do you have jaw pain?	□	□
3. Are you teeth sensitive to sweets?	□	□	12. Do you believe you clench or grind your teeth?	□	□
4. Does food catch between your teeth?	□	□	13. Do you wear dentures or partials?	□	□
5. Is your mouth too dry?	□	□	14. Have you ever had a serious mouth injury?	□	□
6. Have you had any gum treatments in the past?	□	□	15. Do you have anxiety about dental treatment?	□	□
7. Have you ever had orthodontics (braces)?	□	□	16. Have you had any bad dental experiences?	□	□
8. Do you have fluoride in your water?	□	□	17. Have you had problems with past dental work?	□	□
9. Do you have tooth pain?	□	□	18. Are you happy with how your teeth look?	□	□

H) DRUG AND ALCOHOL USE

1. Do you use tobacco? □ Yes □ No What type? About how much per week? _____
2. Do you drink alcohol? □ Yes □ No About how many drinks per week? _____
3. Have you recently used any other recreational drugs? □ Yes □ No

Do you have any other disease, condition, or problem not listed? _____

_____

Signature (*parent/guardian if under 18yo*): _____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

SUPPLEMENTAL INFORMATION

A) DENTAL BENEFITS

Are you using dental benefits towards your treatment

☐ YES ☐ NO

Primary Benefits

Subscriber's Name: _____

Subscriber's Relation To You: ☐ SELF ☐ SPOUSE ☐ PARENT

Subscriber's Birthday: _____ / _____ / _____

Subscriber's Employer: _____

Name of Ins. Company: _____

Secondary Benefits (if any)

Subscriber's Name: _____

Subscriber's Relation To You: ☐ SELF ☐ SPOUSE ☐ PARENT

Subscriber's Birthday: _____ / _____ / _____

Subscriber's Employer: _____

Name of Ins. Company: _____

B) REFERRAL SOURCE

How did you hear about our office?

_____

C) COMMUNICATION PREFERENCES

Your time is valuable and your privacy is important to us. Please tell us the most convenient way to contact you with appointment confirmations and office communications:

Check all that apply: ☐ Phone ☐ Text

☐ Mail ☐ Email: _____

FINANCIAL POLICY & CONSENT

Late cancellation policy. I understand Eagle Dental reserves a dedicated chair and time slot for my appointment. Missed or cancelled appointments with less than 24-hour notice will incur a $40.00 late cancellation fee.

Treatment fees. I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the service, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on the contract between my insurance company or managed care company and me,my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me.

Insurance claims. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any chances thereto.

Assignment of benefits. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and /or managed care company to make payment directly to the dentist for the costs associated therewith.

Delinquent accounts. I acknowledge payment is due within 30 days of service and that a late payment charge of 1% per month will be assessed on any unpaid balance remaining after 30 days. I consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient signature:_____Date_____

Print Name:_____

Guardian/Responsible Party,if minor:_____Date_____

Print Name:_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

NOTICE OF PRIVACY PRACTICES

Effective Dec 2015

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. We will post a copy of our notice in our office. The effective date of the Notice is provided above. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by
state worker's compensation laws.

Academic/Research/Marketing/Communication: We may use your health information for academic, research, or marketing purposes. Information used for these purposes will remain anonymous. We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, text, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below:

Privacy Officer PO Box 271 Eagle, WI 53119 (262) 594-2223