DR. DENTAL

800 Juan Tabo Blvd NE, Ste# Q, Albuquerque, NM 87123

Patient Information

Today's Date*: __mm/dd/yyyy___

Patient Name: _____ _____ _____
Last* First* MI

Gender: _m/f/o_____ Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Partnered ☐ Separated ☐ Minor

Social Security #: _123-45- 6789____ Date of Birth*: _mm/dd/yyy__

Parent or Legal Guardian Name: _____ _____ _____
(For Minor Patients) Last First MI

Relationship to Patient: ☐ Mom ☐ Dad ☐ Step Mother ☐ Step Father ☐ Other: _____
(For Minor Patients)

Best Contact Number *: _123-456-7890_____ Alternative Contact Number: _____ Ext: _____

Best time to call*: _____AM/PM **E-Mail:** _____

Address*: _____ _____
Street* Suite/Apartment#

_____ _____ _____
City* State* Zip Code*

Person responsible for Payment

Relationship to Patients*: ☐Father ☐Mother ☐Self ☐Spouse ☐Other: _____

Name*: _____ _____ _____
Last* First* MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Best Contact Number: _____ Alternative Contact Number: _____ Ext: _____ Best time to call: _____

Address*: Same As Above

_____ _____
Street* Suite/ Apartment*#

_____ _____ _____
City* State* Zip Code*

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____
Phone: _____

Address: _____ _____ _____ _____
Street City State Zip Code

Insurance Information

Primary Insurance

Insurance Plan Name: _____

Name of Primary Policy Holder: _____ Birth Date: _____
Last First MI

ID #: _____ Group #: _____Social Security#:_____

Address: _____
Street City State Zip Code

Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient (**Friend)** ☐ Another patient (**Relative)**

☐ Walk/Drive to Nearby Office ☐ Postcard ☐ Online ☐ Coupons ☐ Social Media ☐ Work Location/ School Event
☐ Other: _____

Name of person or office referring you to our practice: _____

Financial/Insurance Authorization:

All Patients are required to bring at least one Government issued Photo Identification for their appointment. As a Condition of your treatment by this office, financial arrangements must be made prior to leaving the office on the day of your rendered services. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined at the time services are performed.

For patients who carry Dental insurance understand that all dental services rendered are presented in the form of a 'treatment plan' to the patient and that he or she is personally responsible for payment of all dental services not paid by their dental insurance. We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we can make **no guarantee of any estimated coverage**. Please note that your dental policy is an agreement between you and the insurance company, and we ask that **all patients be directly responsible for all charges not paid by the insurance**. If you have any questions or notice any discrepancies regarding your billing statement if you receive one from our office, please contact us immediately.

I hereby authorize my insurance benefits to be paid directly to Dr Dental. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original, I have read the above conditions of treatment and payment and agree to their content.

Today's Date: _mm/dd/yyy__

Print Patient Name: _____ _____
Or Parent/Legal Guardian First Name Last Name

Patient Signature: _____
Or Parent/Legal Guardian

Health Information

NEEDS TO BE UPDATED IMMEDIATELY WHEN CHANGES IN HEALTH INFORMATION OCURR OR ATLEAST EVERY 6 MONTH, EVEN IF NO CHANGES ARE REPORTED

DENTAL HISTORY

Patient Name: _____ DOB: _____

Reason for Today's Visit*: _____

Date of last dental visit: _____ Former Dentist: _____

Address of Former Dentist: _____ Date of last dental x-rays: _____

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

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Cavities
- ☐ Clicking or popping jaw
- ☐ Misaligned teeth
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Broken Teeth
- ☐ Broken Fillings
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/ Growths in your mouth
- ☐ Wisdom teeth pain
- ☐ Other: _____
- ☐ How often do you floss? _____
- ☐ How often do you brush? _____

MEDICAL HISTORY

Office Use Only: Weight: _____ BP: _____ Pulse: _____

Have you ever had or do you have any of the following? Please check Yes or NO:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal Bleeding*	☐	☐	Convulsions*	☐	☐	High Blood Pressure*	☐	☐	Rheumatoid arthritis
☐	☐	Allergy Codeine*	☐	☐	Cortisone Medicine	☐	☐	High Cholesterol	☐	☐	Scarlet Fever
☐	☐	Allergy Latex*	☐	☐	Diabetes*	☐	☐	HIV / AIDS*	☐	☐	Shingles
☐	☐	Allergy Penicillin*	☐	☐	Dialysis *	☐	☐	Hives/ Rash	☐	☐	Sickle Cell Disease
☐	☐	Allergy Sulfa Drugs*	☐	☐	Drug Addiction	☐	☐	Hypoglycemia	☐	☐	Sinus Problems
☐	☐	Alzheimer's disease	☐	☐	Emphysema	☐	☐	Irregular Heartbeat	☐	☐	Spina Bifida
☐	☐	Anaphylaxis*	☐	☐	Endocarditis*	☐	☐	Kidney Problems*	☐	☐	Spleen removed*
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease
☐	☐	Arthritis/Gout	☐	☐	Excessive Bleeding	☐	☐	Liver problems*	☐	☐	Stroke
☐	☐	Artificial Heart Valves*	☐	☐	Fainting	☐	☐	Low Blood Pressure	☐	☐	Thyroid Problems*
☐	☐	Artificial Joints*	☐	☐	Frequent Cough	☐	☐	Lung Disease*	☐	☐	Tobacco usage*
☐	☐	Asthma*	☐	☐	Frequent Headaches	☐	☐	Lupus (SLE)	☐	☐	Tonsillitis
☐	☐	Bisphosphonates Use	☐	☐	Genital Herpes	☐	☐	Mental Disorders	☐	☐	Tuberculosis*
☐	☐	Blood Diseases*	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tumors or Growths
☐	☐	Blood Thinners*	☐	☐	Hay Fever	☐	☐	Organ Transplantation*	☐	☐	Ulcers
☐	☐	Blood Transfusion	☐	☐	Head Injuries	☐	☐	Osteoporosis	☐	☐	Venereal Diseases
☐	☐	Breathing Problems	☐	☐	Heart Attack/Failure	☐	☐	Medication Allergies*			**Women only**
☐	☐	Cancer*	☐	☐	Heart Diseases*			_____	☐	☐	**Are you Pregnant?**
☐	☐	Chemical Dependency*	☐	☐	Heart Murmur	☐	☐	Psychiatric Care	☐	☐	Are you nursing?
☐	☐	Chemotherapy*	☐	☐	Heart Pacemaker*	☐	☐	Radiation Treatment*	☐	☐	Talking Birth Control
☐	☐	Chest pain/ Angina*	☐	☐	Hemophilia	☐	☐	Renal Dialysis*			
☐	☐	Cold Sores/Fever Blisters	☐	☐	Hepatitis* ____ (A, B, C)	☐	☐	Respiratory Problems*			
☐	☐	Congenital Heart defects*	☐	☐	Herpes	☐	☐	Rheumatic Fever			

- Have you ever had any complications following dental treatment*? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been ever hospitalized*? ☐ Yes ☐ No
  If yes when and what for? _____
- Do you wish to speak privately about anything*? ☐ Yes ☐ No
- Do you take any medications currently (including over-the counter drugs)*? ☐ Yes ☐ No
  _____
- Is there any condition concerning your health that the doctor should be told about* ☐ Yes ☐ No
  _____
- List any medication that you are Allergic or that make you sick:
  _____
- Are you now under the care of a physician*? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
  Last medical Appointment: _____
- Do you have any health problems that need further clarification*? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers including patient contact information and Health information provided are true and correct. If I ever have any change in my health, I will inform the dentist at the next appointment without fail.

_____ Today's Date*: mm/dd/yyy_ _____

Full Name of patient or personal representative* Signature*

(Parent or Legal Guardian in case of minors)

GENERAL CONSENT AND AUTHORIZATION

FOR DENTAL AND/OR MEDICAL SERVICES

We at Dr Dental appreciate the opportunity to serve you. It is our intent to provide you with the finest care possible while ensuring that you fully understand our procedures and treatment. To insure that your care comes first, we require your consent for Dr Dental to treat you under all circumstances while in this facility as follows:

The undersigned, on behalf of himself/herself, or minor (if applicable) hereby authorizes and consents to any reasonable Dental or Medical examination, X-ray examination, Anesthetics, Medical or Surgical diagnosis, Treatment and/or transport to hospital care (if deemed necessary) to be rendered by any of our Dentists, licensed in the State of New Mexico.

A parent or legal guardian or family member (Adults) or personal member with written consent must accompany all minors and special needs patients for treatment and remain in treatment or reception area so the minor's history and treatment plan can be discusses and any consent or exam forms signed if needed.

I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.

I understand that any treatment plan that is presented to me is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

I hereby confirm, consent, and agree to the foregoing.

Today's Date: _____

Print Patient Name: _____ _____
Or Parent/Legal Guardian First Name* Last Name*

Patient Signature*: _____
Or Parent/Legal Guardian

ACKNOWLEDGEMENT OF RECIEPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a (Print Patient Name or Legal Guardian Name) * copy of DR.DENTAL's HIPAA *Notice of Privacy Practices.*

I understand that DR. DENTAL's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of DR. DENTAL's revised HIPAA *Notice of Privacy Practices* upon request.

I understand that, if I have question about DR. DENTAL'S *HIPAA Notice of Privacy Practices,* I may speak with Office Coordinator.

I understand that it is my right to refuse to sign this Acknowledgment should I so choose, and that Dr. Dental will not refuse treatment to me if I refuse to sign this Acknowledgment.

I further understand that I may contact the Secretary of U. S. Department of Health and Human Services should I have concerns regarding DR. DENTAL's privacy policies and privacy policies and procedures.

Release of Health Information

Please select <u>one</u> of the following:

[☐ YES ☐ NO] * I authorize the release of information including the diagnosis, Treatment plan, appointments, records; examination rendered to me and claims information.
This information may be released to:

☐ Spouse: _____

☐ Other: _____

[☐ YES ☐ NO] * Information is **NOT** to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Today's Date*: _____

Patient Name/ Legal Guardian Name*: _____

Patient Name / Legal Guardian **Signature***: _____

Legal Guardian Authorization Form

Patient's Name (*printed*):_____ Patients Date of Birth: _mm/dd/yy____

Legal Guardian Name (*printed*):_____

Relationship to Patient: ☐ Mom ☐ Dad ☐ Step Mother ☐ Step Father ☐ Other: _____

I authorize the following persons below to take my child to and from his/her appointments, and to make all necessary decisions to complete major and or minor procedures including (*please check all that apply*):

Full Name: _____ Relationship to Patient: _____

Full Name: _____ Relationship to Patient: _____

☐ Schedule appointments

☐ Dental Cleaning that may include; Examination, radiograph, Prophylaxis, Periodontal treatment & Fluoride treatment.

☐ Oral Surgery

☐ Basic and Minor Restorative treatment

☐ Go over financial information (co-payments, past due balance, account history)

OR

☐ **I DO NOT** authorize anyone else besides the guardians listed on the welcome new patient intake form to bring my child to his/her appointments

Legal guardian Signature*: _____ Date*: _____

DR. DENTAL

COVID-19 PANDEMIC 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*:

Patient Name/ Legal Guardian Name*: _____

_____ _____

Patient /or/ Legal Guardian Signature* Today’s Date*

DR. DENTAL

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*.

Patient Name/ Legal Guardian Name*: _____

_____ _____

Patient /or/ Legal Guardian Signature* Today's Date*