American Dental Care
105 N. Virginia Ave. Suite 103
Falls Church, VA 22046
Telephone: 703-533-7285 Fax: 703-533-7287

Patient Advisory and Acknowledgement

Receiving Dental Treatment During the COVID-19 pandemic

Name: ______________________________ Date: __________________ Temperature__________

Please be advised that while our office complies with the State Health Department and Centers for Disease Control and Prevention with 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 our patients) could be infected, with or without their knowledge. In order to reduce the risk of spreading COVID-19, we are asking the screening questions below and we ask that you be truthful and candid in your answers.

In the past month have you experienced:

1. A fever or flu-like symptoms? YES NO

2.Shortness of breath? YES NO

3.Dry cough or sore throat? YES NO

4.Runny nose? YES NO

5.Notice a change/loss of taste or smell? YES NO

6.pink eye or conjunctivitis? YES NO

7.Have you been COVID-19 positive or being with someone who has? YES NO

8.Have you travelled to any foreign country? YES NO

if so, where____

9.Have you travelled within the United States? YES NO

if so, where____

10.Have you visited a hospital? YES NO

11.Have you visited an Assisted living or Senior Center? YES NO

12.Have you been in a gathering of more than 10 people? YES NO

PATIENT/RESPONSIBLE PARTY: _______________________________DATE: ____________

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Today's date: _______________

Name: ____Preferred: _________________
First MI Last

Male: _______Female: _______ Date of Birth: ________________ (month/date/year)

Title: ______ Marital Status: single _____ married _____ separated_____ divorced _____ widowed_____

Home Address: ____
Street appt # City State Zip code

Home Phone: ___________________ Work phone: ___________________Cell Phone: ___________________

Fax: _______________________________________ Email:____

Company/Employer Name: _____________________________ Position: __________________

Social Security #: __________________

Name of Spouse: ___________________________________Company/Employer Name: __________________

Position: _____________________ Date of Birth: ______________ Social Security #: __________________

Person responsible for this account: ___________________________ Relationship to patient: _______________

FOR INSURANCE VERIFICATION PURPOSE ONLY

Name of Subscriber: ________________________ DOB: ____________________________

Insurance ID #: ____________ Group/policy #: __________

Name of Company (employer) insurance is through: ____

Name of Dental Insurance: _____________________________________Phone: _________________________

Insurance Mailing Address: ____

Insurance Assignment and Release
I certify that I or my dependent is covered by dental insurance with _________________, and assign directly to American Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. American Dental Care may use my or my minor/child's health care information and may disclose such information to the above-mentioned insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services.

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WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
____

Primary Dentist: _________________________________

In Case of emergency, who should we notify?

Name:_____________________________ Phone (cell):_______________Phone (home):___________________

HEALTH QUESTIONNAIRE

MEDICAL HISTORY

1. Name and phone number of Physician: ____
2. When was your last physical exam? ____
3. Do you have any health problems ____ YES NO
4. Have you been hospitalized or had a serious illness/operation in the past five years? __________ YES NO

If yes, please explain, ____

____

5. Do you have, or have you had any of the following diseases or problems? __________________ YES NO
   - Rheumatic fever or rheumatic heart disease____ YES NO
   - Congenital heart lesions, heart murmur or mitral valve prolapse___________________________ YES NO
   - Cardiovascular disease (heart attack stroke, angina or arteriosclerosis) _______________________YES NO
   - High/low blood pressure ____YES NO
   - Hepatitis A, B or C, jaundice or liver disease ____YES NO
   - Seasonal allergies, Asthma or hay fever ____YES NO
   - Fainting spells or seizures ____YES NO
   - Diabetes ____YES NO
   - Arthritis ____YES NO
   - Tuberculosis ____ YES NO
   - Persistent cough or cough up blood ____ YES NO
   - Venereal disease ____ YES NO
   - Hip or Joint replacement____ YES NO
   - Other ____ YES NO
   - Do you need to pre-medicate with an antibiotic before dental appointments? _________________YES NO
     Which antibiotic? ____
   - Abnormal bleeding with extractions, surgery, other _______________________________________YES NO
   - Blood disorders, such as anemia ____YES NO
   - History of surgery or radiation therapy for a tumor, growth in the head or neck _______________YES NO
6. Are you taking any of the following drugs or medications?
   - Antibiotics or sulfa drugs ____YES NO
   - Medication for high blood pressure ____YES NO
   - Anticoagulants (blood thinners) ____ YES NO
   - Cortisone (steroids) ____ YES NO

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- Tranquilizers ______________________________ YES NO
- Aspirin ______________________________ YES NO
- Insulin or similar drugs ______________________________ YES NO
- Digitalis, Nitroglycerine or drugs for heart trouble ______________________________ YES NO
- Hormone therapy ______________________________ YES NO
- Supplements or vitamins ______________________________ YES NO

7. Do you use tobacco products? ______________________________ YES NO
   If so, what kind and how often? ______________________________

8. Are you HIV positive? ______________________________ YES NO
9. Are you allergic or have reacted adversely to:
   - Local anesthetics
   - Penicillin or other antibiotics
   - Sulfa drugs
   - Barbiturates, sedatives
   - Aspirin
   - Ibuprofen
   - Iodine
   - Latex
   - Other
10. Do you have any disease, condition or problem not listed above that we need to know? ________ YES NO

If so, please explain ______________________________

____

Women Only

11. Are you pregnant? ______________________________ YES NO
12. Are you taking Oral Contraceptives? ______________________________ YES NO

DENTAL HISTORY

- How long have you been to the dentist?
- What was done then?
- Did you have x-rays?
- Have you lost any teeth? _______________Why? ______________________________
- Are your teeth sensitive to: Cold Heat Sweets Sour
- How often do you brush your teeth? _____________________ Type of tooth brush_______________
- Do you use dental floss ______________________________ How often? _____________________
- Do you have bleeding gums? _________________ When? ______________________________
- Do you use mouth wash? _________________________Name: ______________________________
- Do you experience pain when brushing or flossing your teeth? ______________________________
- Do you grind or clench your teeth? ________________________ When? ______________________
- Have you had gum treatment? _______________ When and type? ____________________________
- Do you hear popping, clicking or noises when you chew? ______________________________
- Are you aware of any swelling or lump in your mouth? ______________________________
- Have you had any serious trouble associated with previous dental treatment? ____________________

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If so, explain ____

Please describe any current medical treatment, impending operation, or any other medical or dental information that may possible affect your dental treatment: ______________________________

____

Date: ________________________ Signature of Patient ______________________________

Signature of Dentist: ____________________________

AUTHORIZATION TO DISCUSS TREATMENT

I,________________________________, give American Dental Care permission to discuss my case and/or treatment with:

NAME: ______________________________ Relationship: _______________________

NAME: ______________________________ Relationship: _______________________

NAME: ______________________________ Relationship: _______________________

Patient Name: ________________________Relationship to Patient (if minor): ______________

____

____

____

Signature of Patient, Parent, Guardian, or Representative

____

____

____

Date:_____________________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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.

I understand that, under the health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

. Conduct, plan and direct my treatment and follow-up among the various health care providers who may be involved in your treatment directly and indirectly.

. Obtain payment from third-party payers.

. We may use or disclose health information to provide appointment reminders (voice mail, letters, postcards, email and text message), or in connection with our health care operations including quality assessments, improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioners performance, certification, licensing or credentials.

. We may use or disclose health information to notify or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. We will use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

. We may use or disclose your health information when we are required to do so by law.

. We may disclose your health information to appropriate authorities to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others, if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

I have received, read and understand your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this Office has the right to change its notice of privacy practices from time to time and that I may contact this Office at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using our contact information.

Patient Name:____________________________ Relationship to Patient:_____________________

Signature:_______________________________ Date:________________________