COVID-19 Pandemic- Patient Disclosures

This patient disclosure form seeks information from you that we must consider before making tratment dexisions in the circumstance of the COVID-19 virus.

A weak or copromised immune system (including, but not limited to, conditions like diabetes, ashtma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contractiong 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 dislose to this office any indication of having been exposed to COVID-19 virus.

Do you have a fever or above normal temperature?	**Yes**	**No**
Have you exprerienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Have you been in contact woth someone who has tested positive for COVID-19? dfda		
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 outside 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 copromised immune system.

By signing this document, I acknowledge that the answers I have provided abover are true and accurate.

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Signature Date

Center for Implant Dentistry & Oral and Maxillofacial Surgery

PATIENT INFORMATION:

Name: _____ DOB: ____/____/____
Last First Middle

Address: _____
Street City State Zip Code

E-mail: _____ Employer: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Gender: F ___ M___. SSN: _____ Marital Status: _____Spouse name: _____

General Dentist: _____ Phone: _____

DENTAL INSURANCE INFORMATION:

Insured's name: _____Insured's SSN: _____

Insurance Company: _____ Insured's Employer: _____

Plan/Group: _____ Insured's Date of Birth: _____

Preferred Pharmacy name and phone number: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____Phone: _____

Address: _____

MEDICAL HISTORY

Have you ever been treated for?	YES	NO		YES	NO
Rheumatic Fever			Kidney Disease		
Heart Murmur			Bladder Disease		
Heart disease			Arthritis		
Congenital Heart lesions			Artificial Joints Replacement		
High Blood Pressure			Asthma or Hay Fever		
Stroke			Tuberculosis		
Heart Pacemaker			Epilepsy		
Anemia			A.I.D.S/H.I.V.		
Diabetes			Bisphosphonate, Fosamax, Prolia, Xgeva, Reclast etc.		
Hepatitis			Blood Thinners (Coumadin, Plavix, Aspirin etc.)		
Glaucoma			Sinus Infection		
Have you ever had severe bleeding or other complications following an extraction?					
Have you ever been on cortisone or steroid therapy?					
Have you been hospitalized in the past five years?					
Are you pregnant?			How long?		
Are you subject to fainting spells?					
Are you allergic to any drugs, medicines or injections? (if yes, please specified bellow)					
Is there anything else in your medical history that we should be aware of?					

MEDICATIONS:

List of medications you are currently taking	Reason for taking it.

Please add anything you feel is important for the doctor to know:

I do hereby authorize the performance of diagnostic services and dental treatment for the above patient by the dental professionals and the staff of this dental clinic, their assistants, and designees. I further authorize the administration of anesthetics and medications as are deemed necessary. I understand that all diagnostic aids, including radiographs, are the property of the clinic.

Signature: _____Date:_____

If this consent is signed by a parent or guardian on behalf the patient, complete the following:
Parent/Guardian name: _____Relationship to patient:_____

FINANCIAL AND OFFICE POLICY

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

INSURANCE: Your insurance policy is an agreement between you and the insurance company; we are not a party to that contract. We ask that all patients be directly responsible for all charges. Your estimated co-payment and deductibles will be due at the time of service. We are happy to submit the claims necessary to help you receive the full benefits of your coverage; however we cannot guarantee any estimated coverage. All account balances not paid by the insurance company are the responsibility of the patient. We are in network with most of the Detal Insurances; however, we are not in network with Medical Insurances and we do not do Medical Billing in our office.

PAYMENT: We accept : Cash, Visa and MasterCard. In addition, we offer Care Credit, a patient payment program offering a full range of Deferred Interest and Extended Payment Plans for treatment. **We don't accept checks.**

FAILED APPOINTMENTS: We try to remind patients by telephone prior to the appointment- but please do not depend on this courtesy. If we are unable to contact you, your appointment card will serve as your confirmation and implies your obligation to be present. That time has been reserved especially for you. If you need to change your appointment we require 48-hour notice. Our office policy is that **$50.00 will be charged upon a FAILED** appointment.

PHOTO RELEASE: In the course of treatment, it may be necessary to take a photo of your teeth or tissues for diagnostic, restorative or educational purposes. I agree to the release of these images. These images will not contain any identifying facial features or information.

THANK YOU FOR READING OUR FINANCIAL AND OFFICE POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I have read, understand and agree to the above financial and office policy.

Signature_____ Date:_____

HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2013, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordination your treatment.

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given opportunity to ask any questions I may have regarding this Notice.

_____ _____ _____

Patient Signature Patient Name (please print) Date

PATIENT CONSENT

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment.
I understand that such disclosures may not be of the type listed above.

_____ _____ _____

Patient Signature Patient Name (please print) Date

AUTHORIZATION to RELEASE & DISCUSS TREATMENT INFORMATION

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; names must be explicitly stated below**. You may opt out by checking the "Do NOT Release Information" box below.

I give the following named person(s) authorization to take messages, pick up my x-rays or speak with the office of Center for Implant Dentistry & Oral Surgery, on my behalf regarding my appointments, financial, treatment, insurance, radiographic images.

Name of authorized person: _____ Relationship: _____

Name of authorized person: _____ Relationship: _____

Name of authorized person: _____ Relationship: _____

Name of authorized person: _____ Relationship: _____

_____DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient Name :_____ Date of Birth :_____

Signature or Patient or Authorized Representative: _____

Date Signed: _____