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 that 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 with COVID-19 virus is challenging and complicated due to limited availability of 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 healthcare providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the Notice above and fully understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I understand and voluntarily accept the additional risk of contracting COVID-19 from this office. I also acknowledge that I could contract the COVID-19 virus from outside this office wholly 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

JENKINS, MORROW & GAYHEART
ORAL AND MAXILLOFACIAL SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**
You may refuse to sign this acknowledgement**

I ________________, have received a copy of this office's Notice of Privacy Practices.
(Print Patient Name)

____, __________________
Patient Signature or Parent/Guardian Signature Date

I understand that in order for information to be disclosed to anyone other than myself, I must give permission to W. Scott Jenkins, D.M.D., Nick S. Morrow, D.M.D., or Matthew N. Gayheart, D.M.D., M.D.

I give permissions for W. Scott Jenkins D.M.D., M.D., Nick S. Morrow, D.M.D., or Matthew Gayheart, D.M.D., M.D., to discuss information regarding my care/treatment/account to the following listed persons. (**Please Print Names of All that apply**.)

Parent/Guardian Name: ____
Spouse/Partner Name: ____
Referring Dentist/Doctor Name: ____
Friend Name: ____
Brother/Sister Name/s: ____
Child/Children Name: ____
Other: ____

Do not release or discuss my information with the following listed persons:

____ ____

____ ____

For Office Use Only

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency Situation prevented us from obtaining acknowledgement
Other (Please Specify) ____

Health History Form

Patient's Name ____ Date of Birth _____/_________/___________

Gender: Male / Female Height: _________ Weight: __________

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: ____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: ____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why? ____ Date of last physical exam ____/______/_________

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)? Yes No

Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)? Yes No

Kidney disease or kidney failure, requiring dialysis? Yes No

Thyroid disease? Yes No

Stomach ulcers or colitis? Yes No

Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth? Yes No

Frequent or recurring mouth sores? Yes No

Radiation to the head or neck for cancer treatment? Yes No

Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Yes No

Glaucoma? Yes No

Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily? Yes No

Liver disease (jaundice, hepatitis A, B, or C)? Yes No

Diabetes? Yes No

Arthritis? Yes No

Significant weight loss or gain? Yes No

Seizures, convulsions, epilepsy, fainting or dizziness? Yes No

Sinus or nasal problems? Yes No

Osteoporosis or osteopenia? Yes No

Any disease, chemotherapy or transplant operation? Cancer? Yes No
If so, where? ______________________________________, and when was the date of your last treatment? ________________________

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: ____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes? Yes No Relationship ______________ Cancer? Yes No Relationship _____________

Heart disease? Yes No Relationship ______________ Bleeding problems? Yes No Relationship _____________

Tumors? Yes No Relationship ______________ Lung disease? Yes No Relationship ____________

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

Health History Form

Patient's Name ____ Date of Birth _____/_________/___________

MEDICATIONS

Are you using any of the following:

Antibiotics? Yes No

Anticoagulants (blood thinners)? Yes No

Heart drugs? Yes No

Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative-hypnotics and antidepressants Yes No

Prescription pain medication? Yes No

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Yes No

Insulin or oral anti-diabetic drugs? Yes No

High blood pressure medications? Yes No

Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use. Yes No

____

____

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: ____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex? Yes No

Food products? Yes No

Sedatives, barbiturates? Yes No

Codeine or other pain killers? Yes No

Aspirin, Motrin, Aleve, or ibuprofen? Yes No

Penicillin or other antibiotics? Yes No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? ______________ Relationship? _________________

Other drug allergies not listed above: ____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? ____

Have you ever sought professional care or been hospitalized for:

Drug abuse? Yes No

Emotional disorders? Yes No

Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? _____________

Marijuana? Yes No How often? _____________

Recreational drugs? Yes No How often? _____________

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?____________________________

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

____ ____

Signature of patient, parent, guardian Date

____ ____

Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
______________	____	____________________________________
______________	____	____________________________________

JENKINS & MORROW
ORAL AND MAXILLOFACIAL SURGERY

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JENKINS, MORROW & GAYHEART

ORAL AND MAXILLOFACIAL SURGERY

Patient Agreement

Limitation of Practice:
Patient understands that Drs. Jenkins, Dr. Morrow's & Dr. Gayheart's practice is limited to Oral and Maxillofacial Surgery.

Patient Consent:
Patient hereby gives my consent, if needed, for drawing blood samples for diagnosis or in case of accidental puncture of exposure to medical personnel during my course of treatment either in the offices or in the hospital. These tests may include AIDS testing.

Insurance Claims Filing:

In all cases, the patient is responsible for payment of their account.

As a courtesy, Jenkins, Morrow & Gayheart will file a claim to the patient's insurance carrier.

Assignment and Release:
Patient hereby authorizes and assigns applicable insurance benefits to be paid directly to the physician. Patient is financially responsible for non-covered services. Patient authorizes release of information necessary to process insurance claims. Patient authorizes photographs, diagnostic dental models restricted for medical, dental, education or insurance purposes and information release to other practitioners in good faith effort for my medical care. Patient authorizes disclosure of medical record information to JCAHO surveyor in connection with performance of his/her duties as a surveyor.

Deductibles/Co-payments:
Payment of your deductible as well as an estimate of your share (co-payment) of the fee is due at the time services are rendered. Payments can be made in the form of cash, check, Visa, MasterCard or Care Credit. If the insurance pays more or less than the estimated amount you will be billed or reimbursed accordingly. Patient balances are due 30 days after insurance coverage payment has been made.

Unpaid Balances:
If, for any reason, the patient cannot make scheduled payments, the patient must immediately contact the office of Jenkins, Morrow & Gayheart to make acceptable arrangements. Drs. Jenkins, Morrow and Gayheart reserve the right to refer all unpaid accounts to collection agencies. Any fees associated with collection, including collection agency contingency fees and/or court costs, will be added to the patients account balance. After accounts are placed with collection agencies all patient visits and procedures will be conducted on a cash only basis.

Service Charge:

- Drs. Jenkins, Morrow and Gayheart reserve the right to assess a service charge, not to succeed $20.00 per month, to a patient account for any unpaid balance over 30 days after the insurance coverage has been paid.
- A 2% credit card processing surcharge will be applied to all credit card payments.
- Patients whose Ins companies utilize the 3rd party payer ZELIS will also be subject 2% surcharge.

Health Information Privacy Policies and Procedures:
In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been informed of the Privacy Policies and Procedures of Jenkins, Morrow & Gayheart, PLLC. (We have a copy at the front desk.) I understand that I may obtain a copy of these procedures from the receptionist at the front desk upon request.

Patient Name (Print Name)

Patient/Parent/Guardian Signature Date

JENKINS, MORROW & GAYHEART
ORAL AND MAXILLOFACIAL SURGERY

Patient Insurance Information

Welcome to our office. So that we may assist you in filing your dental/health insurance forms, please provide us with the information requested below. All information is kept confidential.

Patient's Name: First_______________Middle Initial_______Last______________________

Sex: Male/Female Age: ______ DOB: _________________ Soc. Sec #: __________________

Address: ____

City: ___________________________ State: __________________ Zip:_______________

Home Phone #: _______________________ Work #: ______________________________

Cell # ___________________ Email Address: _____________________________________

Name of Person Responsible for Account: ____________________________________

Relationship: ___________________ SS#: __________________ DOB: ________________

Billing Address: ____

____

Home Phone#: __________________Work#: _________________ Cell#: ________________

Name of *Dental Insurance* Plan: ____

Group #:_________________________ ID #:____

Subscriber's Name _______________________ Subscriber's Employer: __________________

Subscriber's Soc. Sec. # ____________________________ DOB: _________________________

Relationship to Subscriber: ____

Name of *Medical Insurance* Plan: ____

Group #:________________________________ ID#: ___________________________________

Subscriber's Name: _______________________ Subscriber's Employer: __________________

Soc. Sec. #______________________________ DOB: ____________________________________

Relationship to Subscriber: ____

Referring Dentist/Orthodontist/Physician:____

Reason for Visit: ____

Emergency Contact Name: ___________________________Relationship: _________________

Home Phone: ______________ Work Phone: _______________ Cell Phone: _______________