COVID-19 Pandemic Emergency Dental Treatment

Consent Form

I, ____, knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of that may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not give the current limits in virus testing. Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometime hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. ______________(Initial)
- I have been made aware of the CDC, ODA, and ADA guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. _____________(Initial)
- I confirm I am seeking treatment for a condition that meets these criteria. _____________. (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

Fever

Shortness of Breath

Dry Cough

Runny Nose

Sore Throat

______________(Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID -19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. ________________(Initial)

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. _________________(Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _________________(Initial)

Name: ____Date: __________________

ALABAMA ORAL & FACIAL SURGERY

www.alabamaoralsurgery.com

HENRY E. MCKAY, III DDS CHRISTOPHER M. ROTHMAN, DDS WILL SMALLEY, DMD

PATIENT INFORMATION______________________________DATE____________

Name: ____ Preferred First Name: __________

Patients Address: ______________________________City:______________State: ____Zip:________

Date of Birth ____/______/_______Home#: (____)______________Cell #: (____)______________ Work#:(___)______________

SS#______/_____/_______ SEX:_ M or F_ Marital Status: _M S D W_Email Address: ______________________

Employer Name & Address: ______________________ City: ______________ State: ____Zip: __________

REFERRING INFORMATION______________________________

Referring Dentist: __________ Internet: _____Friend: _____Insurance Website:_________ Other: __________

INSURANCE INFORMATION______________________________

Dental Insurance: ____________________ Policy Holders Name: ______________________
Policy Holder's SS#: _________/________/________ DOB: _______/________/________ Employer: ______________
Member ID/Contract#: __________________ Plan/Group#: ___________

Secondary Dental: ____________________Policy Holders Name: ______________________
Policy Holder's SS# __________/_________/_________ DOB: _______/________/_______ Employer: ______________
Member ID/Contract#: __________________Plan/ Group#: ____________

Medical Insurance: ____________________ Policy Holders Name: ______________________
Policy Holder's SS#: __________/_________/__________ DOB: ______/_______/______Employer: ______________
Member ID/Contract#: __________________Plan/Group#: ___________

Secondary Medical: ____________________Policy Holders Name: ______________________
Policy Holder's SS#: _________/_________/__________DOB: _______/_______/_______Employer: ______________
Member ID/Contract#: __________________Plan/Group#: ___________

EMERGENCY CONTACT INFORMATION______________________________

Name: ______________________Email address: ______________________
Address: ____
Relationship to patient: __________Home#:______________Cell#:______________
Medical information can be discussed with: ______________relationship:______________

DRIVER'S INFORMATION/PERSON RESPONSIBLE DRIVING YOU HOME FROM SURGERY__________

Driver's name______________/Relation__________/Cell #__________DOB:___/___/___

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS OR DISCUSS ANY MEDICAL INFORMATION TO:

____

AUTHORIZATION INFORMATION______________________________

I authorize the Doctor/Staff to perform oral surgery and or examination for the purpose of treatment. I also, authorize the taking of x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. Furthermore, I hereby acknowledge that a copy of this office's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient or legal guardian X______________________________

PATIENT NAME____**DATE** ___________________

ARE YOU IN A PAIN MANAGEMENT PROGRAM: Yes: ___No: ___ **ARE YOU PREGNANT**: Yes:____ No:_____

List any drug allergies: ____
Food allergies: ____

Latex Allergy: Yes____ No_____ **Egg allergy:** Yes____ No ______ **Tobacco User**: Yes_____ No_______

Are you taking any bone building medications such as **FOSAMAX, BONIVA, ACTONEL**,ETC? LIST___________________
Are you taking any blood thinners such as **COUMADIN, PLAVIX, ASPIRIN,** ETC?LIST ____________________________

Have you ever had radiation treatment for cancer to the head or neck? Yes ______No _______
If yes, please list treating doctor's name and phone#: ____

PLEASE PROVIDE US WITH YOUR **PHARMACY NAME & NUMBER**: ____

MEDICAL HISTORY/PLEASE CHECK IF ANY APPLY TO YOU____

____ALZHEIMER
____ASTHMA
____BLEEDING PROBLEMS
____CANCER, TUMOR /TYPE________
____COLITIS
____DIABETES
____EMPHYSEMA
____EPILEPSY/SEIZURE DISORDER
____FAINTING SPELLS
____HEART ATTACK
____HEART DISEASE
____HEART MURMUR
____HEPATITIS ____A____B____C
____HIV POSITIVE
____HIGH BLOOD PRESSURE
____LOW BLOOD PRESSURE
____LIVER DISEASE
____MITRAL VALVE PROLAPSE
____NERVOUS DISORDER
____PROSTHETIC HEART VALVE
____PROSTHETIC (ARTIFICIAL)JOINT REPLACEMENT
____RHEUMATIC FEVER
____SLEEP APNEA
____STEROID THERAPY
____STROKE
____THYROID DISORDERS
____TUBERCULOSIS
____OTHER__________________________________

Please list current medications:___________________
____
____
____
____

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE QUESTIONS ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIREIS SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY SURGEON, OR ANY OTHER MEMBER OF HIS/HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM. **PATIENTS/OR LEGAL GUARDIAN SIGNATURE**____________________________________**DATE:**__________________

ARE YOU RECEIVING GENERAL ANESTHESIA TODAY? YES _____NO_____
IF YES, HAVE YOU HAD ANYTHING TO EAT OR DRINK IN THE LAST SIX HOURS? YES _____NO _____
HAVE YOU HAD SURGERY IN THE LAST 6 MONTHS THAT REQUIRED GENERAL ANESTHESIA? YES ____NO____
PLEASE LIST ANY AND ALL SURGERIES: ____
PATIENTS RECEIVING GENERAL ANESTHESIA MAY NOT BE DROPPED OFF AND DRIVERS AND THE VEHICLES MUST REMAIN AT THE OFFICE AT ALL TIMES.