COVID-19 Pandemic Dental Treatment

Consent Form

I, _____, knowingly and willingly consent to have dental procedure completed during the current COVID-19 virus.
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 situation and understand that my dental issues will be treated unless you are currently experiencing the below listed symptoms. _____(Initial)
- I am confirming I am seeking treatment for a condition that meets the 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** **WALTER WILSON, DMD, MD**

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.