Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Patient Registration

First Name: _____ **MI:** ____ **Last Name:** _____

Preferred Name: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Responsible Party: ☐ Self ☐ Other _____

Contact Information

Patient Address: ☐ Own ☐ Other _____

Address 1: _____

Address 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ ☐ Home ☐ Mobile ☐ Work ☐ Fax **Notes:** _____

Phone Number: _____ ☐ Home ☐ Mobile ☐ Work ☐ Fax **Notes:** _____

Phone Number: _____ ☐ Home ☐ Mobile ☐ Work ☐ Fax **Notes:** _____

Phone Number: _____ ☐ Home ☐ Mobile ☐ Work ☐ Fax **Notes:** _____

Email: _____

Email: _____

Preferences

Dentist: _____ **Hygienist:** _____

Pharmacy: _____

Patient Registration

Previous Dentist: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Notes:

Referral: _____ Referral Source: _____

Additional Identifiers

Emergency Contact: _____

Emergency Contact #: _____

Preferred Pharmacy: _____

Primary Language: _____

SSN: _____

Patient Insurance

Primary Insurance Information

Carrier Name: _____ **Effective Date:** _____

Address 1: _____

Address 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Plan Name: _____ **Policy Holder ID:** _____

Policy Holder: ☐ Self ☐ Other _____ **Policy Holder Date of Birth:** _____

Relationship to Policy Holder: _____ ☐ Dependent Child Coverage Only

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Plan #2 Insurance Information

Carrier Name: _____ **Effective Date:** _____

Address 1: _____

Address 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Plan Name: _____ **Policy Holder ID:** _____

Policy Holder: ☐ Self ☐ Other _____ **Policy Holder Date of Birth:** _____

Relationship to Policy Holder: _____ ☐ Dependent Child Coverage Only

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Plan #3 Insurance Information

Carrier Name: _____ **Effective Date:** _____

Address 1: _____

Address 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Plan Name: _____ **Policy Holder ID:** _____

Policy Holder: ☐ Self ☐ Other _____ **Policy Holder Date of Birth:** _____

Relationship to Policy Holder: _____ ☐ Dependent Child Coverage Only

Medical History Form

Patient Name:

Date of Birth:

Sex:

Emergency Contact _____

Emergency Contact Phone _____

Emergency Contact Relationship _____

Do you have any of the following diseases or problems

Active Tuberculosis ..... No Yes

Persistent cough greater than a 3 week duration ..... No Yes

Cough that produces blood ..... No Yes

Been exposed to anyone with tuberculosis ..... No Yes

Medical History

Are you now under the care of a physician? ..... No Yes

Physician Name _____

Phone (including area code) _____

Address/City/State/Zip _____

Are you in good health? ..... No Yes

Has there been any change in your general health within the past year? ..... No Yes

If yes, what condition is being treated? _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ..... No Yes

If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ..... No Yes

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements

_____

Do you wear contact lenses? ..... No Yes

Joint Replacement. Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? ..... No Yes

Date _____

If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? No Yes

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No

Date Treatment began _____

Do you use controlled substances (drugs)? ..... Yes No

Do you use tobacco (smoking, snuff, chew, bidis)? ..... Yes No

If so, are you interested in stopping? VERY / SOMEWHAT / NOT INTERESTED _____

Do you drink alcoholic beverages? ..... Yes No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY. Are you:

Pregnant ..... Yes No

Number of weeks _____

Taking birth control pills or hormonal replacement? ..... Yes No

Nursing? ..... Yes No

Allergies, Are you allergic to or have you had any reaction to

Local anesthetics	Yes	No	Latex (rubber)	Yes	No
Aspirin	Yes	No	Iodine	Yes	No
Penicillin or other antibiotics	Yes	No	Hay fever/seasonal	Yes	No
Barbiturates, sedatives, or sleeping pills	Yes	No	Animals	Yes	No
Sulfa drugs	Yes	No	Food	Yes	No
Codeine or other narcotics	Yes	No	Other	Yes	No
Metals	Yes	No	If Other, please specify: _____		

Congenital Heart Disease (CHD) - Please indicate if you have had or not had any of the following:

Artificial (prosthetic) heart valve	Yes	No	Congenital heart disease (CHD)	Yes	No
Previous infective endocarditis	Yes	No	Unrepaired, cyanotic CHD	Yes	No
Damaged valves in transplanted heart	Yes	No	Repaired (completely) in the last 6 months .	Yes	No
			Repaired CHD with residual defects	Yes	No

Other Diseases and Conditions - Please indicate if you have had or not had any of the following:

Cardiovascular disease	Yes	No	Heart attack	Yes	No
Angina	Yes	No	Heart murmur	Yes	No
Arteriosclerosis	Yes	No	Low blood pressure	Yes	No
Congestive heart failure	Yes	No	High blood pressure	Yes	No
Damaged heart valves	Yes	No	Other congenital heart defects	Yes	No

Mitral valve prolapse	Yes	No
Pacemaker	Yes	No
Rheumatic fever	Yes	No
Rheumatic heart disease	Yes	No
Abnormal bleeding	Yes	No
Anemia	Yes	No
Blood transfusion	Yes	No
If yes, date _____		
Hemophilia	Yes	No
AIDS or HIV	Yes	No
Arthritis	Yes	No
Autoimmune disease	Yes	No
Rheumatoid arthritis	Yes	No
Systemic lupus erythematosus	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Emphysema	Yes	No
Sinus trouble	Yes	No
Tuberculosis	Yes	No
Cancer/Chemotherapy/Radiation Treatment	Yes	No
Chest pain upon exertion	Yes	No
Chronic pain	Yes	No
Diabetes Type I or II	Yes	No
Eating disorder	Yes	No
Malnutrition	Yes	No
Gastrointestinal disease	Yes	No
G.E. Reflux/persistent heartburn	Yes	No
Thyroid problems	Yes	No
Stroke	Yes	No
Glaucoma	Yes	No
Hepatitis, jaundice or liver disease	Yes	No
Epilepsy	Yes	No
Fainting spells or seizures	Yes	No
Neurological disorders	Yes	No
If yes, please specify _____		
Sleep disorder	Yes	No
Mental health disorders	Yes	No
Specify _____		
Recurrent infections	Yes	No
Type of infection _____		
Kidney problems	Yes	No
Night sweats	Yes	No
Osteoporosis	Yes	No
Persistent swollen glands in neck	Yes	No
Severe headaches/migraines	Yes	No
Severe or rapid weight loss	Yes	No
Sexually transmitted disease	Yes	No
Excessive urination	Yes	No

Premedication

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ..... Yes No

Name of physician or dentist making recommendation (include phone number) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No

Please explain _____

_____

Signature of Patient/Legal Guardian

Delaware Dental
AUTHORIZATION & RELEASE

☐ *I will be paying my estimated co-pay and any applicable deductible only at the time of treatment and my credit card number will be kept on file.* ***I hereby authorize Delaware Dental to keep my signature on file and to charge my credit card account for any and all treatment fees remaining after my insurance carrier has processed my claim, or any balance still remaining after 60 days. Delaware Dental agrees to make every reasonable effort to advise me before this transaction is made.***

_____
Cardholder's Signature

_____
Cardholder's Address (street)

_____
Cardholder's Address (city, state and zip code)

_____
Cardholder's Telephone #

MasterCard Visa AMEX Discover

_____(CV Code)_____
Credit Card Account #

___/___
Exp Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

□ First Name Only □ Proper Surname □ Other _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT, & BILLING INFORMATION** VIA:

□ **Any of the Below** □ Cell Phone Confirmation

□ Text Message to my Cell Phone □ Work Phone Confirmation

□ Home Phone Confirmation □ Email Confirmation

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

□ **Any of the Below** □ Cell Phone Confirmation

□ Text Message to my Cell Phone □ Work Phone Confirmation

□ Home Phone Confirmation □ Email Confirmation

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATEMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Please print name of Patient **Please sign Patient / Guardian of Patient**

_____ _____

Legal Representative / Guardian **Relationship of Legal Representative / Guardian**

- - - - - - - - - - - - - - -

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

□ It was emergency treatment

□ I could not communicate with the patient

□ The patient refused to sign

□ The patient was unable to sign because

□ Other (please describe) _____

Consent for Services and Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

GENERAL
Thank you for choosing our practice as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER & CARE CREDIT

DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ***ESTIMATED*** co-payment on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. After a statement of accounts has been sent and a balance is left on the account after 60 days, the credit card kept on file will be charged for any balance over 60 days.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER
All ESTIMATED portions and deductibles are due prior to treatment. In the event YOUR insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

USUAL AND CUSTOMARY RATES
Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

ADULT PATIENTS
Adult patients are responsible for full payment at time of service.

MINOR PATIENTS
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/MasterCard, American Express, Discover, Care Credit, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS
We respectfully ask that you give us a minimum of 48 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments. There will be a $25 dollar cancellation/no-show fee.

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balance over 60 days past due.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education, training and/or marketing.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

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.

_____

{Signature}

_____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt 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)

_____

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:

_____

Social Security Number:_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Delaware Dental
Telephone: (409)333-1671
Email: officemanager@delawaredental.org
Address: 6330 Delaware Street, Suite A Beaumont, Texas 77706

Agreement As to Resolution of Concerns: I understand that I am entering into a contractual relationship with doctor for professional care. I further understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of healthcare and may result in irreparable harm to a healthcare provider. As additional consideration for professional care provided to me by Doctor, I the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against the Doctor.

Furthermore, should a meritorious medical/dental] malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use expert witness(es) who practice primarily in the same specialty as doctor. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Dental Association.

In further consideration for this, Doctor agrees to the same stipulations.

Mutual Agreement to Maintain Privacy: ***Swarnalatha Bathina*** (collectively labeled "Dentist') agree to provide treatment to "Patient'. The Dentist takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws- For example, dentists are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dentist believes this is improper and may not be in the patients' best interest. Accordingly, Dentist agrees not to provide medical/dental information for the purpose of marketing directly to patient. Regardless of legal privacy loopholes, Dentist will never attempt to leverage its relationship with patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right. tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

This Agreement shall be in force and enforceable for a period of five years from Dentist's last date of service to Patient. As a matter of office policy, Dentist is requiring all patients in its practice sign the Mutual Agreement to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dentist's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Dentist-Patient relationship.

Patient and Dentist acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Dentist agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:_____

Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name:

_____

Relationship to Patient:

_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: Date:

_____ _____