

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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your/their age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they traveled in the past 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

COVID-19 PATIENT ASSESSMENT

To preserve the health of our patients and employees, please complete the following assessment regarding COVID-19. Your responses will help us prevent any unnecessary exposure. Please let us know if you have any questions. Thank you!

Name: _____ Date: _____

Date of Birth: _____ Gender: Male Female

Temperature Upon Arrival: _____

1. Have you been exposed to anyone who has tested positive for COVID-19 in the last two weeks? Yes No
2. Have any members of your household been exposed to anyone who has tested positive for COVID-19 in the last two weeks? Yes No
3. Have you been exposed to anyone who has, or has had any symptoms associated with COVID-19 in the last two weeks? (e.g. dry cough, fever, shortness of breath) Yes No
4. Do any members of your household currently have, or have had, any symptoms associated with COVID-19? (e.g. dry cough, fever, shortness of breath) Yes No
5. Have any members of your household been exposed to anyone who has, or has had, any symptoms associated with COVID-19 in the last two weeks? (e.g. dry cough, fever, shortness of breath) Yes No
6. Have you been advised to seek COVID-19 testing by another healthcare professional in the last two weeks?
 Yes No
7. Have you been advised to self-quarantine by another healthcare provider in the last two weeks?
 Yes No

Patient Signature: _____

Patient Coordinator: _____

*Thank you for helping us prevent any unnecessary exposure to COVID-19!
Your participation will help us flatten the curve and protect our community!*

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 #: _____

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

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

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: _____ Emergency Contact: _____
Date of Birth: _____ Emergency Contact Phone: _____
Sex: _____ Emergency Contact Relationship: _____

Do you have any of the following diseases or problems

Active Tuberculosis Yes No
Persistent cough greater than a 3 week duration Yes No
Cough that produces blood Yes No
Been exposed to anyone with tuberculosis Yes No

Medical History

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

Physician Name: _____

Phone (including area code): _____

Address/City/State/Zip: _____

Are you in good health? Yes No

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

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? Yes No

If yes, what was the illness or problem? _____

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

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

Do you wear contact lenses? Yes No

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

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? Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (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

Sulfite drugs Yes No Food Yes No

Codaine 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 Blood transfusion Yes No

Atrialna Yes No If yes, date: _____

Arteriosclerosis Yes No Hemophilia Yes No

Congestive heart failure Yes No AIDS or HIV Yes No

Damaged heart valves Yes No Arthritis Yes No

Heart attack Yes No Autoimmune disease Yes No

Heart murmur Yes No Rheumatoid arthritis Yes No

Low blood pressure Yes No Systemic lupus erythematosus Yes No

High blood pressure Yes No Asthma Yes No

Other congenital heart defects Yes No Bronchitis Yes No

Mitral valve prolapse Yes No Emphysema Yes No

Pacemaker Yes No Sinus trouble Yes No

Rheumatic fever Yes No Tuberculosis Yes No

Rheumatic heart disease Yes No Cancer/Chemotherapy/Radiation Treatment Yes No

Abnormal bleeding Yes No Chest pain upon exertion Yes No

Anemia 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
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)

**HIPAA OMNIBUS RULE
 PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
 CONSENT/LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgment & 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 RECEPTION AREA:

First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION. (This includes step parents, grandparents and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Text Message to my Cell Phone | <input type="checkbox"/> Work Phone Confirmation |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Any of the Above |

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Text Message to my Cell Phone | <input type="checkbox"/> Work Phone Confirmation |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via:

- | | |
|--|--|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the Above (opt out) |
| <input type="checkbox"/> Email | |

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

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 TREATMENT 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 representative's) signature on this Acknowledgment 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) _____

Signature of Privacy Officer: _____

Delaware Dental
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, 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.

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.

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____

**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

Credit Card Account # _____ (CV Code) _____

Exp Date

Delaware Dental
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

E-mail: officemanager@delawaredental.org

Address: 6330 Delaware Street, Beaumont, TX 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 DDS and Delaware Dental (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 so as 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 health care operations.

Signature: _____

Date: _____

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

Personal Representative's 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.

REVOCAION 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: _____