



ADVANCED DENTAL ARTS

FAMILY • COSMETIC • IMPLANT DENTISTRY

COVID-19 DENTAL TREATMENT CONSENT

I, _____, knowingly and willingly consent to have dental treatment completed during the COVID19 pandemic.

I understand the COVID19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given 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 sometimes hours, which can transmit the COVID19 virus.

- I understand that due to the frequency of visits of other dental patients, characteristics of the virus, and the characteristics of the dental procedures, that I have elevated risk of contracting the virus simply by being in a dental office. _____(initial)
- I have been made aware of the CDC 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 COVID19 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 COVID19 virus. I understand that 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 of the USA in the past 14 days to countries that have been affected by COVID19. _____(initial)
- I verify that I have not traveled domestically within the USA by commercial airline, bus, or train within the past 14 days. _____(initial)

Patient Name_____

Date _____

Witness Name_____

Date _____



ADVANCED DENTAL ARTS

FAMILY • COSMETIC • IMPLANT DENTISTRY

Thank you for choosing Advanced Dental Arts and trusting us with your most treasured gift - Your Smile. We look forward to meeting you, building a relationship with you and taking care of your dental needs. If there is anything we can do to help make your visit a more comfortable experience, please don't hesitate to ask. We hope you find yourself in a place you can call your dental home.

Confidential Dental and Medical History

Patient's Name _____ Age _____ Date of Birth _____

Address _____ City, State, Zip _____

Home Phone _____ Cell _____

Work Phone _____ E-mail _____

Best Contact: EMAIL CELL TEXT HOME SS# _____

Marital Status: SINGLE MARRIED WIDOWED DIVORCED Employer _____

Spouse's Name _____ Spouse's Phone: (Work) _____ (Cell) _____

Emergency Contact _____ Relation _____ Emergency Phone _____

Do you have dental insurance? YES NO If YES, Insurance Carrier's Name _____

Group # _____ Phone # _____ Subscriber's Name _____

Relation to Patient _____ Subscriber's SS# _____ Subscriber's Date of Birth _____

Subscriber's Employer/Co. Name _____

How did you hear about us? _____



ADVANCED DENTAL ARTS

FAMILY • COSMETIC • IMPLANT DENTISTRY

Office Policy Regarding Dental Insurance:

Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. I understand that I am required to pay my “Estimated Patient Portion” and any deductible due, to Advanced Dental Arts at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. Any portion of treatment that the insurance does not cover is the patient’s responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full at time of service, regardless of any delay in payment(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility.

SIGNATURE

DATE



Medical History

In order for us to provide you with the safest and best possible care, please complete these Medical & Dental History forms. All information is kept strictly confidential.

Have you taken any prescription drugs during the last 6 months? YES NO PLEASE LIST.

Are you taking any over the counter medications or herbal supplements? YES NO PLEASE LIST.

Are you allergic to (i.e. itching, rash, swelling) or made sick by any medication? PLEASE LIST.

Any surgeries and/or hospitalizations? YES NO PLEASE LIST.

Have you ever had any excessive bleeding requiring special treatment? YES NO PLEASE LIST.

Have you ever taken drugs by mouth or by injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer? YES NO PLEASE LIST.

Have you ever been told to take antibiotics prior to dental treatment? YES NO

Use of alcohol: YES NO | DAILY WEEKLY MONTHLY Use of recreational drugs: YES NO

Do you use tobacco? YES NO What type and how much per day?

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

LOW BLOOD PRESSURE	KIDNEY PROBLEMS	SEIZURES /EPILEPSY	LEUKEMIA
HIGH BLOOD PRESSURE	SEXUALLY TRANSMITTED DISEASES	ALLERGIES / SINUS TROUBLE	BRUISE/BLEED EASILY
HEART DISEASE /ATTACK	ACID REFLUX	ASTHMA/BRONCHITIS	OSTEOPOROSIS
ANGINA PECTORIS	ULCERS	EMPHYSEMA/COPD	ARTHRITIS
ARTIFICIAL HEART VALVE	LIVER FAILURE	CHEMOTHERAPY	JOINT REPLACEMENTS
HEART FAILURE	HEPATITIS/JAUNDICE	RADIATION TREATMENT	SLEEP APNEA
HEART PACEMAKER	DIABETES TYPE I OR II	HIV/AIDS	EXCESSIVE DAYTIME SLEEPINESS
STROKE	THYROID / GLAND PROBLEMS	ANEMIA	

Are you pregnant now? YES NO	Practicing birth control? YES NO	Plan to become pregnant? YES NO
------------------------------	----------------------------------	---------------------------------

PLEASE READ THE FOLLOWING CAREFULLY: To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

SIGNATURE

DATE

DOCTOR'S SIGNATURE

DATE

DentalHistory

Answers to these questions help us provide safe and effective dental care personalized to your individual needs.

ARE ANY OF YOUR TEETH SENSITIVE TO:

YES NO

Hot or cold?
Sweets?
Biting or chewing?
Have you noticed any mouth odors or bad taste?
Do you frequently get cold sores?
Do you frequently get oral ulcers?
Do your gums bleed or hurt?
Have you noticed any loose teeth?
Have your teeth shifted over the years?
Does food tend to become caught in between your teeth?

DO YOU:

Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning?
Have a hard time opening wide?
Mouth breathe while awake or asleep?
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Clicking or popping of the jaw?
Pain in the jaw joint area near the ear?
Difficulty in opening or closing your mouth?
Headaches, neckaches, or shoulder aches frequently?
Sore muscles in the neck or shoulders?

I WOULD LIKE TO LEARN MORE ABOUT:

Dental Implants	Veneers	Invisalign	Cosmetic Dentistry
Whitening	Bridges	Dentures	Other _____

When was your last dental visit? _____

What was completed during your last dental visit? _____

Last dental x-rays? _____ How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (electric brushes, toothpick, etc.) _____

Do you have any dental problems that you are aware of now? If yes, please describe. _____

Do you feel nervous about dental treatment? If yes, what is your biggest concern? _____

SIGNATURE

DATE

Acknowledgment Of Receipt Of Notice Of Privacy Practices

I, _____, have received a copy of the NOTICE OF PRIVACY PRACTICES. I hereby authorize you to share/disclose my health information with the following persons/parties:

TYPE NAME

Patient Signature

NAME OF LEGAL GUARDIAN

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority/relationship.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES document, 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) _____



Photo Release Form

I, _____ (the Releasor) give Advanced Dental Arts (the Releasee) the permission to use my photos for education purposes.

I am aware that my photos may be presented to other patients in a photo album and may be used in Advanced Dental Arts advertising as well. This may include commercials, brochures, books or any other communications.

___ I am **CONSENTING** to **showing my face** in the photos.

___ I am **DECLINING** to show my face in the photos. Only pictures of my teeth will be shown.

___ I understand that I may revoke this authorization at any time by notifying Advanced Dental Arts in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time, destroyed or archived

I agree to release and discharge Advanced Dental Arts, staff, agents, successors and assignees from all and any manner of actions, cause of action, suits, damages, claims or demands whatsoever arising out of or in connection with said photos.

To enter into this agreement with Advanced Dental Arts I represent that I am of lawful and proper age necessary to enter this agreement with Advanced Dental Arts or that I am the legal guardian of the underage participant in said photos.

I certify that I have read the foregoing prior to any use of my photos and I am fully familiar with and agree to the contents thereof.

Patient Signature

Date

Guardian's Signature (if patient is under the age of 18)

Date



Cancellation Policy

Routine appointments require a 24-HOUR advance notice to reschedule.

This will allow us time to offer your reserved appointment to someone who is waiting for an appointment and may also be in pain.

We know there are things that happen in life like flat tires, illness, and unforeseen circumstances that do come up. If you just let us know, we can help another patient with a dental emergency instead.

There is a \$25.00 broken appointment fee that will be charged for less than the required notice of cancelling or changing an appointment.

Thank you.

SIGNATURE

DATE

Financial Arrangements

Payment is due at time of service. Patients with insurance will be expected to pay their “Estimated Patient Portion” which is calculated based upon the information we receive from the particular insurance company. This estimated amount will be due on or before the day of service. Any balance due after the insurance has paid will be billed to the patient and due within thirty (30) days of the statement date.

Payment options:

- » Cash, Cashier’s Check, Personal Check
- » MasterCard, VISA, Discover, American Express, FSA, HSA
- » Patient Financing - We work with several financial organizations that will allow you to get the treatment you need now and spread the payments over as much as 60 months, including “no-interest” programs.



Our mission is to help you to achieve the best possible dental health. Our job is to evaluate the state of your oral health and then discuss with you our findings and potential treatment options. We will always give you all of the options that pertain to your condition. Your job is to determine what treatment option is best for you, and the pace at which you wish to proceed with your treatment. We will gladly respect your decisions.

SIGNATURE

DATE