OFFICE USE

PATIENT # _____

Fredericksburg Implant & Oral Surgery Associates

Patient Information

1. **Name** _____
2. **Birth date** _____ **Sex** _____ **Marital Status** _____
3. **Social Security #** _____
4. **Address** _____

   _____

   City_____ **State**_____ **Zip** _____
4. **Home Phone ( )** _____**Work Phone ( )** _____
5. **Cell Phone ( )** _____
6. **Employer Name**_____
7. **Employer Address** _____
8. **Relation to Guarantor**_____
9. **Referred by: General Dentist:** _____

   Specialist: _____ **Other:** _____

10. **Preferred Pharmacy** _____**Phone:**_____

Pharmacy Address:

If *patient is a minor, please complete the following*:

FATHER

1. **Name**_____
2. **Date of Birth**_____
3. **Social Security #**_____
4. **Address** _____

   _____

   City _____

   State _____ **Zip Code**_____
5. **Home Phone ( )** _____
6. **Work Phone ( )** _____
7. **Employer Name** _____
8. **Employer Address** _____

   _____

MOTHER

1. **Name**_____
2. **Date of Birth**_____
3. **Social Security #**_____
4. **Address** _____

   _____

   City _____

   State _____ **Zip Code** _____
5. **Home Phone ( )** _____
6. **Work Phone ( )** _____
7. **Employer Name** _____
8. **Employer Address** _____

   _____

<u>In case of emergency</u>, please contact:

Name _____ **Home Phone ( )** _____

Address _____ **Work Phone ( )** _____

Medical Insurance

Insurance Company _____
Identification #: _____
Group # _____
Insurance Company Address _____
_____
Insurance Company Phone ( ) _____

Dental Insurance

Insurance Company _____
Identification #: _____
Group # _____
Insurance Company Address _____
_____
Insurance Company Phone ( ) _____

Subscriber (Policy Holder) Information

1. **Relationship to Patient**_____
2. **Name** _____
3. **Address** _____
4. **City** _____ **State** _____ **Zip Code** _____
5. **Phone** _____
6. **Birth date** _____
7. **Social Security #** _____
8. **Employer** _____

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment that is provided. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

×_____ __ _____
Signed (Patient, or parent if minor) **Date**

Language for Consent/Acknowledgement

Use and Disclosure of Protected Health Information

I understand that Keyoumars Izadi, MD, DDS may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the practice and individuals involved in my care in the practice may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at (540) 371-4131.

I understand that I have the right to request that the practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the practice is not required to agree to a requested restriction. However, if the practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the practice, or individuals involved in my care in the practice, have already used or disclosed protected health information in reliance on my prior consent.

×_____ _____ _____
Patient or Legal Surrogate **Date** **Relationship to Patient**

FINANCIAL CONTRACT

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after final insurance correspondence; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands that Medical/Dental Insurance claims may be billed by the provider as a courtesy if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the Federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I: ( ) am **an** active duty member of the U.S. Armed Forces
( ) **am not** an active duty member of the U.S. Armed Forces

DATE:_____ _____
Responsible Party

FREDERICKSBURG IMPLANT & ORAL SURGERY

Authorization for Release of Information to Family Members

Patient Name_____ Date of birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Fredericksburg Implant & Oral Surgery to release my medical, billing and or appointments (date/time) information to the following individual(s):

1._____ Relation to patient: _____

2._____ Relation to Patient: _____

3._____ Relation to Patient: _____

Patient Information:
I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.
You have the right to revoke this consent in writing.

Preferred method of contact:

- o I authorize Fredericksburg Implant & Oral Surgery to send information regarding fees and appointment information via email.

Email: _____

- o I authorize Fredericksburg Implant & Oral Surgery to leave message regarding fees and appointment information via voice mail.

Phone: _____Alternative Phone: _____

Signature: _____Date:_____

Health Questionnaire

FREDERICKSBURG IMPLANT & ORAL SURGERY ASSOCIATES

Patient Name:_____ Birth Date:_____ Chart Number:_____

Age: _____ Sex: _____ Height: _____ Weight: _____

PLEASE ANSWER ALL QUESTIONS AND FILL IN BLANK SPACES WHERE INDICATED. ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

1. Have you had food or drink today? Yes No
2. Are you in good health? Yes No
3. Your last physical examination was on _____
4. Are you now under the care of a physician? Yes No
   If so, what is the condition being treated?
   _____
5. Name and Telephone Number of Physician _____
   _____
   _____
6. Have you had any serious illness, operation, or been hospitalized? Yes No
   If yes, what was the problem and when?_____
   _____
7. Do you drink alcoholic beverages? Yes No
8. Please answer yes or not to all items below. Have you had any of the following illnesses?

	Yes	No
AIDS	_____	_____
Allergies	_____	_____
Anemia	_____	_____
Angina	_____	_____
Arthritis	_____	_____
Artificial Joint Replacement	_____	_____
Asthma	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Emphysema	_____	_____
Epilepsy	_____	_____
Fainting	_____	_____
Glaucoma	_____	_____
Heart Attack	_____	_____
Heart Bypass	_____	_____
Heart Problem	_____	_____
Hepatitis	_____	_____
High Blood Pressure	_____	_____
HIV Positive	_____	_____
Kidney Disease	_____	_____
Liver Problem	_____	_____
Low Blood Pressure	_____	_____
Lung Disease	_____	_____
Rheumatic Fever	_____	_____
Stroke	_____	_____
Thyroid	_____	_____
Tuberculosis	_____	_____
Venereal Disease	_____	_____

Other:_____

9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No
   A. Do you bruise easily? Yes No
   B. Have you ever required a blood transfusion? Yes No
   If "yes" explain circumstances_____
   _____
10. Do you have any blood disorder such as anemia? Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition in you mouth or lips? Yes No
12. Are you taking any drug or medicine? Yes No
    If "yes" what medication _____
13. Are you taking any of the following?
    A. Antibiotics or sulfa drugs Yes No
    B. Anticoagulants (blood thinner) Yes No
    C. Medicine for high blood pressure Yes No
    D. Cortisone (steroids) Yes No
    E. Tranquilizers Yes No
    F. Aspirin Yes No
    G. Insulin, Tolbutamid Yes No
    H. Digitalis or drugs for heart problems Yes No
    I. Nitroglycerin Yes No
    J. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, Aredia or Zometa for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? Yes No
    K. Other_____
14. Are you allergic or have you reacted adversely to:
    A. Iodine Yes No
    B. Local anesthetic Yes No
    C. Penicillin or other antibiotics Yes No
    D. Sulfa drugs Yes No
    E. Barbiturates, sedatives, sleeping pills Yes No
    F. Aspirin Yes No
    G. Other_____
15. Have you had any adverse reaction associated with previous dental treatment? If so explain_____
    _____
16. Have you had any adverse reaction associated with previous medical treatment? If so explain_____
    _____
17. Are you pregnant? Yes No

I have filled out this health questionnaire completely. I have Advised you of all medical problems of which I am aware.

_____
Patient Signature Date

I have reviewed the health history form above.

_____
Doctor Signature Date

COVID-19 PANDEMIC DENTAL TREATMENT
NOTICE AND ACKNOWLEDGEMENT OF RISK

_____ _____

Patient's Name Date of Birth

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures can create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

Patient Acknowledgement

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature (optional) Date

Revised May 15, 2020

COVID-19 PANDEMIC PATIENT DISCLOSURES

_____ _____

Patient's Name Date of Birth

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19, also known as "Coronavirus," pandemic.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that such disclosures may impact treatment decisions.

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. These symptoms may appear 2-14 days after exposure to the virus. It is important that you disclose any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Pre-Appointment		In-Office	
	Yes	No	Yes	No
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐	☐	☐
Have you tested positive for COVID-19?	☐	☐	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐	☐	☐
Have you traveled outside the United States or to high-risk areas in the past 14 days?	☐	☐	☐	☐
Do you have a fever or above normal temperature?	☐	☐	☐	☐
Have you taken any fever-reducing medications, including: ibuprofen (Advil, Motrin or other), acetaminophen (Tylenol or other), naproxen (Aleve or other) or aspirin in the last 14 days and, if yes, for what reason? _____	☐	☐	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐	☐	☐
Do you have a cough?	☐	☐	☐	☐
Do you have a runny nose?	☐	☐	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐	☐	☐
Do you have a sore throat?	☐	☐	☐	☐
Have you experienced chills or repeated shaking with chills?	☐	☐	☐	☐
Do you have muscle pain?	☐	☐	☐	☐
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐	☐	☐	☐
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐	☐	☐	☐
Do you otherwise feel unwell?	☐	☐	☐	☐

COVID-19 PANDEMIC PATIENT DISCLOSURES

_____ _____

Patient's Name Date of Birth

I fully understand and acknowledge the above information, risks and cautions and have disclosed to my provider any other conditions in my health history. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature (optional) Date

Revised May 15, 2020