RIVERBANK
MODERN DENTISTRY
Committed To Dental Excellence

COVID-19 Medical History Update

Dear Valuable Patient of Riverbank Modern Dentistry,
All of us are concerned about the recently diagnosed cases of Coronavirus (COVID-19) in the United States, as well as in the rest of the world. Riverbank Modern Dentistry, in accordance with the guidelines recommended by the Centers for Disease Control and Prevention and the American Dental Association, is helping to prevent the spread of the COVID-19 by following the recommended safety precautions, including the collection of the short medical/travel history below. We appreciate your cooperation in completing these few questions so that together we can do our part to keep you and all of the members of our local community safe and healthy.

PATIENT INFORMATION

Patient's Name _____**DOB:**_____ **Date**_____

Contact email_____ **Cell phone:**_____

- **What dental treatment are you requesting (symptoms, history)?** _____

_____

Please circle (yes) or (no) for each question:

1. Have you tested for COVID-19 in the past 2 months? *Yes* *No* If yes, when did the symptoms abate (date)? _____
2. Do you currently have COVID-19 symptoms or are you under mandatory isolation? *Yes* *No*
3. Have you had close contact with someone diagnosed with COVID-19 or with any symptoms mentioned in question 5 below? *Yes* *No*
4. Are you currently experiencing, or have experienced recently within the last 3 weeks?
   - Coughing *Yes* *No*
   - fever or feeling feverish *Yes* *No*
   - shortness of breath or difficulty in breathing *Yes* *No*
   - loss of taste/smell *Yes* *No*
   - other COVID-19 symptoms (sore throat, headache, fatigue, abdominal pain, diarrhea, chills) *Yes* *No*
5. Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? *Yes* *No*
6. One of the recommendations by dental clinicians is to have patient rinse with 1% Hydrogen Peroxide before any dental work. Would you be okay to rinse your mouth with 1% Hydrogen Peroxide? *Yes* *No*
7. Are you allergic to Hydrogen Peroxide rinse? *Yes* *No*

By my signature below, I agree that the foregoing is true and correct to the best of my knowledge.

Patient Name: _____

Patient/Guardian Signature: _____**Date:** _____

Thank you once again for your cooperation and helping us to create safe environment for everyone in our community

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COVID-19 Treatment Consent Form

I, _____consent to receive dental treatment from Riverbank Modern Dentistry during the COVID-19 outbreak. I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted. I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period or by having direct contact with infectious secretions from someone with COVID-19. I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread. I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- loss of taste/smell
- other COVID-19 symptoms (sore throat, headache, fatigue, abdominal pain, diarrhea, chills)
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that I do not display or currently have any of the symptoms that are representative of COVID- 19, which are outlined above: _____(Initial)

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC (Center for Disease Control), should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____ (Initial)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days. _____(Initial)

Patient Name: _____Patient/Guardian Signature: _____ Date: _____

Team member Name: _____Team member Signature: _____ Date: _____

For Riverbank Modern Dentistry's Internal Use Only:

Patient's Temperature taken? ☐*Yes* ☐*No*	**Finding: _____**	**Team member's Initial**
1% H2O2 provided to patient? ☐*Yes* ☐*No*	**If No, Reason: _____**	**Team member's Initial**

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Welcome

Welcome to Riverbank Modern Dentistry. We appreciate the trust placed on us to provide dental services. To help you service better, please complete the following form. (Bienvenidos al Riverbank Modern Dentistry. Agradecemos la confianza depositada en nosotros para proporcionar servicios dentales. Para ayudarle a un mejor servicio, por favor completa el siguiente formulario.)

PATIENT INFORMAITON

Patient's Last name (Apellido del paciente):_____First name (Nombre del paciente):_____
Middle name (Segundo Nombre) :_____Preferred name (Nombre preferido):_____
Gender: (Género): Male ☐ Female ☐ single/soltero ☐ married/casado ☐ child/niño ☐
Date of Birth (Fecha de nacimiento): _____ Age (Edad) :_____SS #: _____

Occupation (Ocupación):_____Employer(Empleador):_____
Email (Correo electronico):_____
Cell (Celular):_____Home phone (teléfono de casa):_____
Preferred contact method (Método preferido de contacto): Home/ Casa ☐ cell/cellular ☐

Home address:_____
(La dirección de la casa) : Street Address (dirección) City (Ciudad) State (Estado) Zip (Código Postal)

Billing Address (if different):_____
(Dirección de facturación) : Street Address (dirección) City (Ciudad) State (Estado) Zip (Código Postal)

Emergency contact name(Nombre de la persona en caso de emergencia):_____
phone (teléfono):_____Relation(Relación):_____

Responsible Party (Persona Responsable):_____ SSN#_____
Date of Birth(Fecha de nacimiento): _____ _ Relation to Patient(Relación con el Paciente):_____
Driver license number and state (Número de licencia de conducir y el estado):_____

INSURANCE INFORMATION

Primary Dental Insurance (Seguro Dental Primario)

Policy(Numero de Polisa) #_____Groups (Grupos) #:_____

Secondary Dental Insurance (Seguro Dental Secundario)

Policy(Numero de Polisa) #_____Groups (Grupos) #:_____

Subscriber Name (Nombre del Asegurado):_____

Date of birth(Fecha de nacimiento):_____SS #:_____

How did you hear about us? (¿Cómo se entero de nuestra oficina?)_____
Previous dentist's name and address(Nombre del dentista anterior y dirección):_____
_____

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HEALTH HISTORY

Patient's Physician's name and contact number:

_____
_____
_____

HISTORIA de SALUD

Nombre Médico número de contacto del paciente:

_____
_____
_____

DENTAL HISTORY

How may we help you today?

_____
_____

Your current dental health is:

❑ ***Good*** ❑ ***Fair*** ❑ ***Poor***

Are you currently in pain? ❑ ***Yes*** ❑ ***No***

Have you ever had gum treatment? ❑ ***Yes*** ❑ ***No***

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ ***Yes*** ❑ ***No***

Do your gums bleed? ❑ ***Yes*** ❑ ***No***

How many times do you:

Floss/ day? _____

brush/day?_____

Are your teeth sensitive to hot, cold or anything else? ❑ ***Yes*** ❑ ***No***

Have you ever had a serious/difficult problem with any previous dental work? ❑ ***Yes*** ❑ ***No***

When was your last dental cleaning?

_____

HISTORIA DENTAL

¿Cómo podemos ayudarle hoy?

_____
_____

Su salud dental actual es:

❑ ***Bueno*** ❑ ***Justo*** ❑ ***Pobre***

¿Está usted actualmente en el dolor? ❑ ***Sí*** ❑ ***No***

¿Alguna vez ha recibido tratamiento de las encías? ❑ ***Sí*** ❑ ***No***

¿Tiene ahora o ha tenido cualquier dolor o molestia en la articulación de la mandíbula? (TMJ) ❑ ***Si*** ❑ ***No***

Le sangran las encías? ❑ ***Sí*** ❑ ***No***

¿Cuántas veces usted:

Floss / día? _____

cepillo / día ?_____

Son sus dientes sensibles al calor, frío o algo más? ❑ ***Sí*** ❑ ***No***

¿Alguna vez ha tenido una dificultad seria con cualquier trabajo dental anterior? ❑ ***Sí*** ❑ ***No***

¿Cuándo fue su última limpieza dental?

_____

GENERAL HEALTH HISTORY

I. CIRCLE APPROPRIATE ANSWER :

1. ***Yes*** ***No*** Is your general health good?
2. ***Yes*** ***No*** Has there been a change in your Health within the last year?
3. ***Yes*** ***No*** Have you been hospitalized or had a serious illness in the last Three years?
   If YES, why?

_____
_____
_____

HISTORIA GENERAL DE SALUD

I. MARQUE CON UN CÍRCULO LA RESPUESTA CORRECTA :

1. ***Sí*** ***No*** ¿Está en buena salud general?
2. ***Sí*** ***No*** ¿Han habido cambios en su salud durante El último año?
3. ***Sí*** ***No*** ¿Ha estado hospitalizado/a o ha tenido de una enfermedad grave en los últimos tres años?
   ¿Si Sí, por qué?

_____
_____
_____

4. Yes No Are you being treated by a Physician now? For what? _____ _____ Date of last medical exam:_____	***4. Sí No*** ¿Se encuentra actualmente bajo tratamiento médico? ¿Para qué? _____ _____ Fecha de su último examen médico:_____
II. HAVE YOU EXPERIENCED?	**II. HA NOTADO:**
5. Yes No Bleeding problems, bruising easily? ***6. Yes No*** Fainting spells? ***7. Yes No*** Seizures?	***5. Sí No*** ¿Problemas de sangramiento, moretes? ***6. Sí No*** ¿Desmayos? ***7. Sí No*** ¿Convulsiones?
III. DO YOU HAVE OR HAVE YOU HAD:	**III. TIENE O HA TENIDO:**
8. Yes No Heart disease? ***9. Yes No*** Heart attack, heart defects? ***10. Yes No*** Heart murmurs? ***11. Yes No*** Rheumatic fever? ***12. Yes No*** Stroke, hardening of arteries? ***13. Yes No*** High blood pressure? ***14. Yes No*** Asthma, TB, emphysema, other Lung diseases? ***15. Yes No*** Hepatitis, other liver disease? ***16. Yes No*** Stomach problems, ulcers? ***17. Yes No*** AIDS ***18. Yes No*** Tumors, cancer? ***19. Yes No*** Arthritis, rheumatism? ***20. Yes No*** Eye diseases? ***21. Yes No*** Skin diseases? ***22. Yes No*** Anemia? ***23. Yes No*** VD (syphilis or gonorrhea)? ***24. Yes No*** Herpes? ***25. Yes No*** Kidney, bladder disease? ***26. Yes No*** Thyroid, adrenal disease? ***27. Yes No*** Diabetes? ***28. Yes No*** Osteoporosis? ***29. Yes No*** Allergies to: Drugs, foods, Jewelry, Latex, Metals or any medications (Aspirin, Codeine, Ibuprofen, Vicodin, Dental Anesthetics, Erythromycin, Penicillin, Amoxicillin, Tetracycline, and Clindamycin) or any other things not listed above._____ _____	***8. Sí No*** ¿Enfermedades del corazón? ***9. Sí No*** ¿Infarto de corazón, defectos en el corazón? ***10. Sí No*** ¿Soplos en el corazón? ***11. Sí No*** ¿Fiebre reumática? ***12. Sí No*** ¿Apoplejía, endurecimiento de las arterias? ***13. Sí No*** ¿Presión sanguínea alta? ***14. Sí No*** ¿Asma, tuberculosis, enfisema, otras enfermedades ***15. Sí No*** ¿Hepatitis, otras enfermedades del hígado? ***16. Sí No*** ¿Problemas del estómago, úlceras? ***17. Sí No*** ¿SIDA? ***18. Sí No*** ¿Tumores, cáncer? ***19. Sí No*** ¿Artritis, reuma? ***20. Sí No*** ¿Enfermedades de los ojos? ***21. Sí No*** ¿Enfermedades de la piel? ***22. Sí No*** ¿Anemia? ***23. Sí No*** ¿Enfermedades venéreas (sífilis o pulmonares? gonorrea)? ***24. Sí No*** ¿Herpes? ***25. Sí No*** ¿Enfermedades renales (riñón), vejiga? ***26. Sí No*** ¿Enfermedades de tiroides o glándulas? ***27. Sí No*** ¿Diabetes? ***28. Sí No*** Osteoporosis (hueso densidad)? ***29. Sí No*** ¿Alergias a : remedios, alimentos, joyas,De látex,metales o cualquier otro medicamento(Aspirina, Codeína, Iburpufen, Vicodin, Dental Anesthetics, Eritromicina, Penicilina,Amoxicilina, Tetraciclina, Clindamicina) o cualesquiera otros elementos no mencionados anteriormente. _____ _____
IV. DO YOU HAVE OR HAVE YOU HAD:	**VI. TIENE O HA TENIDO:**
30. Yes No Psychiatric care? ***31. Yes No*** Radiation treatments? ***32. Yes No*** Chemotherapy? ***33. Yes No*** Prosthetic heart valve? ***34. Yes No*** Artificial joint?	***30. Sí No*** ¿Tratamiento psiquiátrico? ***31. Sí No*** ¿Tratamientos de radiación? ***32. Sí No*** ¿Quimioterapia? ***33. Sí No*** ¿Válvula artificial del corazón? ***34. Sí No*** ¿Articulación artificial?

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35. Yes No Hospitalization? ***36. Yes No*** Blood transfusions? ***37. Yes No*** Surgeries? ***38. Yes No*** Pacemaker?	***35. Sí No*** ¿Hospitalizaciones? ***36. Sí No*** ¿Transfusiones de sangre? ***37. Sí No*** ¿Cirugías? ***38. Sí No*** ¿Marcapasos?
V. ARE YOU TAKING?	**V. ESTÁ TOMANDO:**
39. Yes No Drugs, medications, over-the-counter medicine (Including Aspirin, Blood thinners, Osteoporosis (bone density) Medicine, Recreational drug ? Please list:_____ _____ _____ _____ ***40. Yes No*** Tobacco in any form?	***39. Sí No*** ¿Remedios, medicamentos, medicamentos sin receta(incluyendo aspirina, sangre anticoagulants, Osteoporosis (hueso densidad) medicina,droga recreativa Liste por favor:_____ _____ _____ _____ _____ ***40. Sí No*** ¿Tabaco de cualquier tipo?
VI. WOMEN ONLY:	**VI. SÓLO PARA MUJERES:**
41. Yes No Are you or could you be pregnant Or nursing? ***42. Yes No*** Taking birth control pills?	***41. Sí No*** ¿Está o podría estar embarazada o dando pecho? ***42. Sí No*** ¿Está tomando pastillas anticonceptivas?
VII. ALL PATIENTS: ***43. Yes No*** Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain: _____ *I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including diagnosis and the records to any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental 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 consent to the dental x-rays, diagnostic procedures and treatment by the dentist necessary for proper dental care. By signing this I authorize communications for my health information via unsecured email & I understand that I have the right to revoke the authorization at any time after written notice from me* **Patient's (or Legal Guardian's) signature:** _____ **Date:**	**VII. PARA TODOS LOS PACIENTES:** ***43. Sí No*** ¿Tiene o ha tenido alguna otra enfermedad o problema médico que NO está en este cuestionario? Si la respuesta es afirmativa, explique: _____ *Yo certifico que he leído y entendido la información anterior a lo mejor de mi conocimiento. Las preguntas anteriores han sido correctamente contestadas. Entiendo que proveer información incorrecta puede ser peligroso para mi salud. Yo autorizo al dentista a divulgar mi información, incluyendo el diagnóstico y los registros de cualquier tratamiento o exámenes rendidos a mi hijo o yo durante el período de la atención dental a los contribuyentes como de terceros y / o profesionales de la salud. Yo autorizo y solicito a mi compañía de seguros a pagar directamente al dentista o un seguro de grupo de los beneficios dentales de otro modo pagadero a mí. Entiendo que mi compañía de seguros dentales puede pagar menos de la cuenta real de servicios. Estoy de acuerdo en ser responsable del pago de todos los servicios prestados en mi nombre o mis dependientes. Doy mi consentimiento a la radiografía dental, los procedimientos de diagnóstico y tratamiento por el dentista necesarias para el cuidado dental apropiado. Al firmar este Autorizo la comunicación de mi información de salud a través de correo electrónico segura y entiendo que tengo el derecho de revocar la autorización en cualquier momento después de la notificación escrita por mí.* **Paciente(o tutor legal de) firma:** _____ **Fecha :**

Dentist's signature: _____ **Date:**_____
Additional Comments (By dentist only) _____

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INSURANCE AND FINANCIAL POLICY

At Riverbank Modern Dentistry, we believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Our goal is to provide outstanding dental care to hundreds of patients every year. Some have dental benefits but some don't. Whether you have dental benefits or you don't, here are some important things you should know about our insurance and financial policy.

Initial

_____ ■ Riverbank Modern Dentistry does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash, and checks. If you are in need of an extended finance option, we also work with many financial companies, who offers 3, 6, 12 or 24 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____ ■ ***A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hour notice to avoid a $35 cancellation fee (emergencies are an exception).***

_____ ■ In the event, If you fail to appear for your appointments, you will be responsible for all the lab costs associated with your dental treatment. In addition, we will charge $100/hour (maximum 3 hours) for the time spent during the above mentioned dental work.

_____ ■ Patients will be responsible for any additional charges associated with their debt & past due balances after 60 days e.g. Collection agency's fees/charges.

_____ ■ Patients will be responsible for additional 10% monthly finance charge on delinquent account balance after 60 days.

_____ ■ Patients will be charged $50 for requesting dental records & X-rays electronically or via regular mail.

I understand and agree with the above conditions.

Please print patient's name: _____Date: _____

Patient's (or Legal Guardian's) signature: _____

FOR INSURED PATIENT ONLY

Initial

_____ ■ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

_____ ■ We will bill your insurance as a courtesy. If insurance does not pay within 60 days, Riverbank Modern Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

I understand and agree with the above conditions.

Please print patient's name: _____Date: _____

Patient's (or Legal Guardian's) signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I have read and received a copy of this office's: ***Dental Materials Fact Sheet dated May, 2004.***

_____

Please print patient's name

_____

Patient's (or Legal Guardian's) signature ***Date***

ACUSE DE RECIBO DE MATERIALES DENTALES HOJA

He leído y recibido una copia de esta oficina: ***Materiales Dentales Hoja de Datos, con fecha de Mayo de 2004.***

_____ _____

Por favor escriba el nombre del paciente

_____

Paciente(o tutor legal de) firma **Fecha**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this Form *

I have read and received a copy of this Riverbank Modern Dentistry's: **Notice of Privacy Practices**

_____

Please patient's print name

_____

Patient's (or Legal Guardian's) 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 (specify)

HIPPA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

This form is used to obtain acknowledgement of our notice of Privacy Practices or to document our good faith to obtain that acknowledgement.

Notice of privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient after September 22nd, 2013. We must make good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Therefore, we must distribute the Notice to each new patient at the time of service and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.