Silicon Valley Surgical Arts

Patient's Name ______________________ Date of Birth ______________________

COVID-19 PANDEMIC PATIENT DISCLOSURES

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?	☐	☐		☐	☐

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____________________________________ ________________________

Patient’s Name Date of Birth

What is the patients’ current vaccination status? *(Please select one below)*:
❑ Not vaccinated ❑ 1st Dose ❑ 2nd Dose ❑ Booster

Please list the name of the vaccine(s): ____

What dates were they administered?: ____

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 Date

______________________________ ___________

Witness Signature (optional) Date

Oral & Maxillofacial Surgery

PATIENT INFORMATION:

Today's Date 07/07/2023

❑ Mr. ❑ Mrs. ❑ Ms. First Name ________ M.I. ____ Last Name ________

Sex: ❑ Male ❑ Female Birth Date ________ Age ____ Soc. Sec. # ________ E-mail ________

❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed ❑ Student

Street ________ Apt. ____ City ________ State ____ Zip ____

Home Tel.(____) ________ Cell.(____) ________ Referred By ________ (FIRST NAME) ________ (LAST NAME)

Dentist ________ (FIRST NAME) ________ (LAST NAME) Orthodontist ________ (FIRST NAME) ________ (LAST NAME)

Employer ________ Bus. Tel.(____) ________ Ext ____

In case of emergency, please contact ________ Tel. (____) ________ Relation ________

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self ❑ Other ________

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name ________ (FIRST NAME) ________ (LAST NAME) Relation ________ S.S.# ________ Birth Date ________

Street ________ Apt. ____ City ________ State ____ Zip ____

Tel. (____) ________ Employer ________ Bus. Tel.(____) ________

PRIMARY DENTAL INSURANCE COMPANY:

Employer ________

Insurance Company Name ________ I.D. # ________

Address ________ City ________ State ____ Zip ____

Tel.(____) ________ Group Name ________

Group # ________ Insured Party ________ Relation ________

Birth Date ________ Sex: ❑ M ❑ F S.S. # ________ Tel.(____) ________

SECONDARY DENTAL INSURANCE COMPANY:

Employer ________

Insurance Company Name ________ I.D. # ________

Address ________ City ________ State ____ Zip ____

Tel.(____) ________ Group Name ________

Group # ________ Insured Party ________ Relation ________

Birth Date ________ Sex: ❑ M ❑ F S.S. # ________ Tel.(____) ________

PRIMARY MEDICAL INSURANCE COMPANY:

Employer ________

Insurance Company Name ________ I.D. # ________

Address ________ City ________ State ____ Zip ____

Tel.(____) ________ Group Name ________

Group # ________ Insured Party ________ Relation ________

Birth Date ________ Sex: ❑ M ❑ F S.S. # ________ Tel.(____) ________

Patient's Name ____________________

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? ____________________

		Yes	No
1.	***Height*** ________ ***Weight*** ________ Are you in good health?	❏	❏
2.	Have there been any changes in your general health in the past year?	❏	❏
3.	Are you under the care of a physician? ***Date of last visit*** ________	❏	❏
	If so, for what are you being treated? ________		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❏	❏
	If so, describe ________		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❏	❏
	If so, describe where ________		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** ________	❏	❏
7.	Have you had a heart valve replacement or vascular graft?	❏	❏
8.	Have you ever had general anesthesia or IV sedation?	❏	❏
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia or IV sedation?	❏	❏
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❏	❏

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Tobacco use? ❏ Smoking, # of packs a day ________ ❏ Chewing			
30. Marijuana use? ❏ Smoking ❏ Edible			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			
37. Gallbladder trouble?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Fainting spells?			
39. Convulsions / epilepsy?			
40. Stroke?			
41. Thyroid trouble?			
42. Diabetes?			
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Stomach ulcers / acid reflux?			
51. Contagious diseases?			
52. Sexually transmitted diseases?			
53. Problems with immune system? Possibly from medication / surgery, etc.			
54. A tumor or growth?			
55. Cancer / radiation therapy / chemotherapy?			
56. Chronic fatigue / night sweats?			
57. Are you on a diet?			
58. A history of alcohol abuse?			
59. A history of drug abuse?			
60. Contact lenses?			
61. Eye disease / glaucoma?			
62. Mental health problems / anxiety / depression?			
63. A removable dental appliance?			
64. Pain or clicking of the jaw joints when eating?			

Patient's Name ______________________

WOMEN ONLY: *(QUESTIONS 65–68)*

	Yes	No
65. Is there a possibility of pregnancy?	❏	❏
66. Expected delivery date? ______________________		
67. Are you nursing?	❏	❏
68. Are you taking birth control pills?	❏	❏

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO	NOTES
69. Any kind of medication, drug, pills?			
70. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
71. Have you ever taken diet pills?			
72. Any natural product, herbal supplement or homeopathic remedy?			
73. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV– Zometa, Aredia, Xgeva, Prolia, or Reclast in the past 12 years?			
74. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:			

75. Please list any medications you are currently taking:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

HAVE YOU HAD AN ALLERGIC REACTION, I.E. RASH OR ITCHING, TO ANY OF THE FOLLOWING:	YES	NO	NOTES
76. Local anesthetic (numbing meds.)?			
77. Penicillin?			
78. Other antibiotics?			
79. Sulfa drugs?			
80. Sodium pentothal / Valium /other tranquilizers?			
81. Aspirin?			
82. Amoxicillin?			
83. Codeine or other narcotics?			
84. Latex?			
85. Soy?			
86. Eggs / yolk?			
87. Sulfites?			
88. Do you have any known allergies?			

89. Please list any allergies other than drug allergies:

90. Please list any other medication or antibiotic you are allergic to:

Is there a family history of:

❏ Cancer ❏ Diabetes ❏ Heart disease ❏ Anesthesia problems

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

INSURANCE PAYMENT AUTHORIZATION

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. (click here to see our Notice of Privacy Practices HIPAA form)

X ______________________ **X** __________ **X** ______________________ **X** __________

Signature of patient *(Parent or Guardian if Minor)* **Date** **Reviewed by** **Date**

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