COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT

NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

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 create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non-essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are “potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection.” The ADA also recommends that urgent dental care which “focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments” be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

Signature Date

_____

Witness

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 virus.

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 we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	**No**
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry 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 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 by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____

Witness

Demographic Information
Información demográfica

PATIENTS NAME: _____ DATE OF BIRTH: _____
NOMBRE DEL PACIENTE *Fecha de nacimiento*

Address: _____ APT. _____
Dirección *Apartamento*

City: _____ State: _____ ZIP Code: _____
Ciudad *Estado* *Código postal*

Cell Phone #: _____ Home Phone #: _____
Teléfono móvil # *Teléfono de casa #*

Emergency Contact Phone #: _____ Dentist Referred By: _____
Teléfono de contacto de emergencia *Dentista recomendado por*

Patients SSN: _____ EMAIL Address: _____
Número de Seguro Social del Paciente *Correo electrónico*

Dental Insurance Carrier: _____
Aseguradora dental

Relationship to Primary Subscriber: SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER ☐
Relación con el miembro primario *Yo* *Esposo(a)* *Dependiente* *Otro*

Members Name: _____
Nombre del miembro

Members DOB: _____ Members SSN: _____
Fecha de nacimiento del miembro *Número de Seguro Social del Miembro*

Employer: _____ Work Phone #: _____
Empleador *Teléfono del trabajo #*

Employer Address: _____
Dirección del trabajo

City: _____ State: _____ ZIP Code: _____
Ciudad *Estado* *Código postal*

Medical Insurance Carrier: _____ Plan Name: _____
Compañía de seguros médicos *Nombre del plan*

Pharmacy Name: _____
Nombre de la farmacia

Address: _____ Phone: _____
Dirección *Teléfono*

Medical History
Historial médico

Patient's Name: _____ Age: _____ Height: _____ Weight: _____
Nombre del paciente *Años* *Estatura* *Peso*

Date: _____ Date of Birth: _____ Sex M ☐ F ☐
Fecha *Fecha de nacimiento* *Sexo*

Patient's primary preferred language is / El idioma preferido principal del paciente es: ☐ English / Ingles ☐ Spanish / Español

		Yes/Si	No	Notes
1.	Are you in pain or discomfort? / *Tienes dolor o malestar*? If yes, is pain severe or moderate? (Circle one) / *Si es así, ¿el dolor es severo o moderado? (Un círculo)*	☐	☐	
2.	Are currently under a doctor's orders or taking any medicine or birth control? *Está actualmente bajo las órdenes de un médico o tomando algún medicamento o anticonceptivo*? Please list medications. *Por favor liste los medicamentos*	☐	☐	
3.	Do you have any bleeding disorders? / *Tienes algún trastorno hemorrágico*?	☐	☐	
4.	Are you subject to fainting, dizziness, convulsions or epilepsy? *Está sujeto a desmayos, mareos, convulsiones o epilepsia?*	☐	☐	
5.	Have you ever had any breathing difficulty such as asthma, pneumonia, tuberculosis or other lung disorder? *Alguna vez ha tenido alguna dificultad para respirar, como asma, neumonía, tuberculosis u otro trastorno pulmonar?*	☐	☐	
6.	Are you pregnant or breastfeeding? *Estás embarazada o amamantando?*	☐	☐	
7.	Are you allergic to any foods, drugs or medicine such as penicillin, aspirin, codeine, novocaine or others? *Es usted alérgico a algún alimento o medicamento como la penicilina, aspirina, codeína, novocaína u otros?*	☐	☐	
8.	Have you ever received I.V. or oral bisphosphonates such as zometa, aredia, Fosamax, Actonel or Boniva, used to treat osteoporosis and or cancer? *Has recibido tratamiento intravenoso o bifosfonatos orales como zometa, aredia, Fosamax, Actonel o Boniva, utilizados para tratar la osteoporosis y el cáncer?*	☐	☐	
9.	Do you use tobacco products, smoke or chew tobacco? *Usa productos de tabaco, fuma o mastica tabaco?*	☐	☐	

HAVE YOU EVER HAD / ALGUNA VEZ HAS TENIDO

	Yes/Si	No
Heart Problems *Problemas del corazón*	☐	☐
Heart Murmur *Soplo cardíaco*	☐	☐
Stroke *Derrame*	☐	☐
Kidney Disease *Enfermedad del riñon*	☐	☐
Diabetes *Diabetes*	☐	☐
Hip or Joint Replacement *Reemplazo de cadera o articulación*	☐	☐
What time did you eat or drink last? *A qué hora comiste o bebiste?*		
Are planning to drive home? *Está planeando conducir a casa?*		
Do you have a cold, cough, or sinus trouble? *Tiene un resfriado, tos o problemas de sinusitis?*		

	Yes/Si	No
Hepatitis or liver disease *Hepatitis o enfermedad hepática.*	☐	☐
High or low blood pressure *Presión arterial alta o baja*	☐	☐
Any blood disease *Cualquier enfermedad de la sangre*	☐	☐
Any other diseases *Cualquier otra enfermedad*	☐	☐

Please list /Favor de listar _____

_____

Date: _____ Time: _____

Yes/Si ☐ No ☐

Yes/Si ☐ No ☐

X _____
PATIENT/GUARDIAN SIGNATURE *I PACIENTE 0 PARIENTE LEGAL*

X _____
Doctors Signature

Informed Consent Authorization
Autorización de Consentimiento Informado

PATIENTS NAME: _____ DATE OF BIRTH: _____
NOMBRE DEL PACIENTE *Fecha De Nacimiento*

RELATIONSHIP TO PRIMARY SUBSCRIBER: SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER ☐
RELACION AL ASEGURADO PRIMARIO: *Yo* *Esposo(a)* *Dependiente* *Otro*

MEMBERS NAME: _____
NOMBRE DEL ASEGURADO:

As the patient/guarantor, it is my responsibility to know if I have dental coverage at the time of service. If I do not provide proof of coverage on the day of service, I will be financially responsible for all services rendered at the time of service. In the event I have dental coverage at the time of service, and did not provide proof of coverage at the time of service, I will not seek reimbursement back from the treating dentist or dental practice and will accept the amount reimbursed by my dental plan as payment in full.

Como paciente / garante, es mi responsabilidad saber si tengo cobertura dental en el momento del servicio. Si no proporciono prueba de cobertura el día del servicio, seré financieramente responsable de todos los servicios prestados al momento del servicio. En el caso de que tenga cobertura dental en el momento del servicio, y no proporcioné el comprobante de cobertura en el momento del servicio, no solicitaré el reembolso al dentista tratante ni a la práctica dental y aceptaré la cantidad reembolsada por mi plan dental como pago completo.

X _____
PATIENT/GUARDIAN SIGNATURE *I PACIENTE 0 PARIENTE LEGAL*

AUTHORIZATIONS

I HAVE BEEN INFORMED OF THE TREATMENT PLAN AND ASSOCIATED FEES. I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIALS NOT PAID BY MY DENTAL BENEFIT PLAN, UNLESS PROHIBITED BY LAW, OR THE TREATING DENTIST OR DENTAL PRACTICE HAS A CONTRACTUAL AGREEMENT WITH MY PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES. TO THE EXTENT BY LAW, I CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT PAYMENT ACTIVITIES IN CONNECTION WITH THIS CLAIM.

ME HAN INFORMADO SOBRE EL PLAN DE TRATAMIENTO Y LAS TARIFAS ASOCIADAS. ACEPTO SER RESPONSABLE DE TODOS LOS CARGOS POR SERVICIOS Y MATERIALES DENTALES NO PAGADOS POR MI PLAN DE BENEFICIOS DENTALES, A MENOS QUE LO PROHÍBA LA LEY, O EL DENTISTA TRATANTE O EL CONSULTORIO DENTAL TENGA UN ACUERDO CONTRACTUAL CON MI PLAN QUE PROHÍBA LA TOTALIDAD O UNA PARTE DE DICHOS CARGOS. EN LA MEDIDA EN QUE LO PERMITA LA LEY, CONSIENTO SU USO Y DIVULGACIÓN DE MI INFORMACIÓN MÉDICA PROTEGIDA PARA LLEVAR A CABO ACTIVIDADES DE PAGO EN RELACIÓN CON ESTE RECLAMO.

X _____
PATIENT/GUARDIAN SIGNATURE *I PACIENTE 0 PARIENTE LEGAL*

Notice of Privacy Practices / Payment Authorization
Aviso de Prácticas de Privacidad / Autorización de Pago

PATIENTS NAME: _____ DATE OF BIRTH: _____
NOMBRE DEL PACIENTE *Fecha de Nacimiento*

RELATIONSHIP TO PRIMARY SUBSCRIBER: SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER ☐
RELACION AL ASEGURADO PRIMARIO: *Yo* *Esposa* *Dependiente* *Otro*

MEMBERS NAME: _____
NOMBRE DEL ASEGURADO:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
EFFECTIVE DATE APRIL 14, 2003
I understand that, under the health insurance portability and accountability of 1996 (HIPAA) I Have certain rights to privacy regarding my health information. I understand this information can and will be used to:

- **Conduct and direct my treatment among mutual healthcare providers;**
- **Obtain payment and billing for reimbursement for services and confirm coverage;**
- **Conduct normal health care operations;**
- **I have received and read your notice of privacy practices. I have been given the opportunity to ask questions I may have regarding this notice.**

AVISO DE RECONOCIMIENTO DE PRÁCTICAS DE PRIVACIDAD
FECHA EFECTIVA 14 DE ABRIL DE 2003.
Entiendo que, según la portabilidad y la responsabilidad del seguro de salud de 1996 (HIPAA), tengo ciertos derechos de privacidad con respecto a mi información de salud. Entiendo que esta información puede y será utilizada para:

- *Conducir y dirigir mi tratamiento entre proveedores de atención médica mutuos;*
- *Obtenga el pago y la facturación para el reembolso de los servicios y confirme la cobertura;*
- *Realizar operaciones normales de atención de salud;*
- *He recibido y leído su aviso de prácticas de privacidad. Se me ha brindado la oportunidad de hacer las preguntas que pueda tener con respecto a este aviso.*

X _____
PATIENT/GUARDIAN SIGNATURE *I PACIENTE 0 PARIENTE LEGAL*

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the named dentist or dental entity.
Por la presente autorizo y pago directo de los beneficios dentales que de otra manera me serían pagados, directamente al dentista o entidad dental nombrada.

X _____
PATIENT/GUARDIAN SIGNATURE *I PACIENTE 0 PARIENTE LEGAL*

Disclosure of Acceptance of Financial Responsibility Agreement

Divulgación de la aceptación del acuerdo de responsabilidad financiera

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PATIENTS NAME: _____ DATE OF BIRTH: _____

NOMBRE DEL PACIENTE *Fecha de nacimiento*

RELATIONSHIP TO PRIMARY SUBSCRIBER: SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER ☐

RELACION AL ASEGURADO PRIMARIO: *Yo* *Esposo(a)* *Dependiente* *Otro*

MEMBERS NAME: _____

NOMBRE DEL ASEGURADO:

The Patient or the Patient's legal representative hereby acknowledges that he or she has been informed that the following health care services to be provided to the patient have not been approved for payment under the patient's health benefit program.
El Paciente o el representante legal del Paciente reconocen que han sido informado de que los siguientes servicios de atención médica que se brindarán al paciente no han sido aprobado para su pago conforme al programa de beneficios de salud del paciente.

Accordingly, the undersigned agrees that the Patient or Patient's legal representative and not the applicable health benefit program will bear full financial responsibility for payment of all charges for these services. If the Patient's health benefit program denies any covered services rendered, the Patient or Patients legal representative will bear full financial responsibility for payment of all charges for those services.
En consecuencia, el suscrito acepta que el representante legal del paciente o el paciente y no el programa de beneficios de salud aplicable asumirá la responsabilidad financiera total del pago de todos los cargos por estos servicios. Si el programa de beneficios de salud del Paciente niega los servicios cubiertos prestados, el Representante legal del Paciente o Paciente asumirá la responsabilidad financiera total del pago de todos los cargos por esos servicios.

Code/Description	Tooth/Surface	Non-Covered Services Amount

Date of Service: _____
Fecha de Servicio

X _____
Printed Name of Patient or Patient Legal Representative
Nombre impreso del paciente o representante legal del paciente

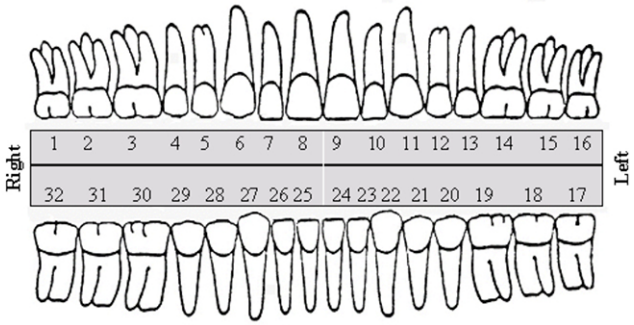
X _____
Signature of Patient or Patient Legal Representative
Firma del paciente o representante legal del paciente

X _____
Office Representative/Witness

Consent for Oral & Maxillofacial Surgery and Anesthesia
Consentimiento para Cirugía Oral y Maxilofacial y Anestesia

PATIENTS NAME: _____ DATE: _____
NOMBRE DEL PACIENTE *Fecha*

Your Planned Treatment is / ***Su tratamiento planificado es***



☐ General Anesthesia / Anestesia general

x

Patient Signature / Firma del paciente

Surgical Procedures, including extraction of teeth, is an irreversible process. As with any surgery, there are some risks. They include, but are not limited to, the following: ***/ Los procedimientos quirúrgicos, incluida la extracción de dientes, es un proceso irreversible. Al igual que con cualquier cirugía, existen algunos riesgos. Incluyen, entre otros, los siguientes:***

1. Post-operative discomfort and swelling that may require several days of at-home recovery. ***Malestar e hinchazón postoperatorios que pueden requerir varios días de recuperación en el hogar.***
2. Prolonged or heavy bleeding that may require additional treatment. ***Sangrado prolongado o intenso que puede requerir tratamiento adicional.***
3. Injury or damage to adjacent teeth or fillings. ***Lesión o daño a los dientes o empastes adyacentes.***
4. Post-operative infection that may require additional treatment. ***Infección post-operatoria que podría requerir tratamiento adicional.***
5. Stretching of the corners of the mouth that may cause cracking or bruising, and may heal slowly. ***Estiramiento de las comisuras de la boca que puede causar grietas o moretones y puede curarse lentamente.***
6. Restricted mouth opening during healing; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist. ***Abertura de la boca restringida durante la curación; a veces relacionado con la hinchazón y el dolor muscular, y otras veces relacionado con el estrés en las articulaciones de la mandíbula (TMJ), especialmente cuando ya existen problemas de TMJ.***
7. A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications***. La decisión de dejar un pequeño trozo de raíz en la mandíbula cuando su extirpación requeriría una cirugía extensa o el riesgo de otras complicaciones.***
8. Fracture of the jaw (usually only in more complicated extractions or surgery). ***Fractura de la mandíbula (generalmente solo en extracciones o cirugía más complicadas).***
9. Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums or tongue, and which may persist for several weeks, months or, in rare instances, permanently. ***Lesión en el nervio que se encuentra debajo de los dientes inferiores, lo que ocasiona dolor, entumecimiento, hormigueo u otras alteraciones sensoriales en la barbilla, labios, mejillas, encías o lengua, y que pueden persistir durante varias semanas, meses o, en raras ocasiones, permanentemente.***
10. Opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment. ***Apertura del seno (una cámara normal situada sobre los dientes superiores) que requiere cirugía o tratamiento adicional.***
11. Dry socket (loss of blood clot from extraction site). Pain a few days after surgery requiring additional care. ***Zócalo seco (pérdida de coágulo de sangre del sitio de extracción). Dolor unos días después de la cirugía que requiera cuidados adicionales.***
12. Allergic reactions (previously unknown) to any medications used in treatment. ***Reacciones alérgicas (previamente desconocidas) a cualquier medicamento utilizado en el tratamiento.***

Consent for Oral & Maxillofacial Surgery and Anesthesia
Consentimiento para Cirugía Oral y Maxilofacial y Anestesia

PATIENTS NAME: _____ DATE: _____
NOMBRE DEL PACIENTE *Fecha*

During the course of treatment unforeseen conditions may be revealed that may require changes in the procedure and treatment. I authorize my doctor and staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery. ***Durante el curso del tratamiento se pueden revelar afecciones imprevistas que pueden requerir cambios en el procedimiento y el tratamiento. Autorizo a mi médico y al personal a utilizar el criterio profesional para realizar los procedimientos adicionales que sean necesarios y deseables para.***

Anesthetic Risks include: discomfort, swelling, bruising, infection and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, does carry with it the rare risks of heart irregularities, heart attack, stroke, brain damage or even death. ***Los riesgos anestésicos incluyen: molestias, hinchazón, moretones, infecciones y reacciones alérgicas. Puede haber inflamación en el sitio de una inyección intravenosa (flebitis) que puede causar molestias y / o discapacidades prolongadas y puede requerir atención especial. Las náuseas y los vómitos, aunque son poco frecuentes, pueden ser efectos secundarios desafortunados de la anestesia intravenosa. La anestesia intravenosa es un procedimiento médico serio y, aunque se considera seguro, conlleva los riesgos poco frecuentes de irregularidades cardíacas, ataque cardíaco, accidente cerebrovascular, daño cerebral o incluso la muerte.***

I understand I am not to have anything to eat or drink for (6) hours before my surgery and to do otherwise may be life threatening. It is important to have any regular medications, using a small sip of water. ***Entiendo que no debo comer ni beber nada durante las (6) horas previas a mi cirugía y que, de lo contrario, podría poner mi vida en peligro. Es importante tener algún medicamento regular, usando un pequeño sorbo de agua.***

I have read and fully understand the above, have had my questions answered, and give my consent to surgery and anesthesia (if applicable). ***He leído y entiendo completamente lo anterior, he recibido respuesta a mis preguntas y doy mi consentimiento para la cirugía y la anestesia (si corresponde).***

Patient to write by hand / Paciente para escribir a mano.

- I have read and fully understand this consent document
- He leído y entiendo completamente este documento de consentimiento

x _____

_____ _____
Patient's (or Legal Guardian's) Signature / Firma del paciente (o tutor legal) Date / Fecha

_____ _____
Doctor's Signature / Firma del doctor Date / Fecha

_____ _____
Witness's Signature / Firma del testigo Date / Fecha

Notice of Privacy Practices
Aviso de Prácticas de Privacidad

Acknowledgement of Receipt Patients Number _____
Acuse de recibo

This is the last page and I acknowledge that I received a copy of Manhattan Oral Facial Surgery LLC – Notice of Privacy Practices.

Esta es la última página y reconozco que recibí una copia de Manhattan Oral Facial Surgery LLC - Aviso de prácticas de privacidad.

Patients Name: _____
Nombre del paciente

Signature _____
Firma

Date _____
Fecha