COVID-19 QUESTIONNAIRE

PATIENT DISCLOSURES:

Patient Name Elizabeth Adkins **Birth Date** 09/03/1949

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 or taste?	❑	☑
Do you have a sore throat?	❑	☑
Have you been in contact with someone who has tested positive for COVID-19?	❑	☑
Have you been tested for COVID-19?	❑	☑
If so, have you tested ❑ Positive ❑ Negative ❑ 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.

X Elizabeth A Adkins **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X 9/18/2020 **Date**

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

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.

X Elizabeth A Adkins **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Doctor**

X 9/18/2020 **Date**

Welcome to our Practice

Today's Date 09/18/2020

PATIENT INFORMATION:

❑ Mr. ☑ Mrs. ❑ Ms. ❑ Dr. First Name Elizabeth M.I. A Last Name Adkins

Sex: ❑ Male ☑ Female Birth Date 09/03/1949 Age 71 Soc. Sec. # 416-72-9001 E-mail anni@anniadkins.com

Street 1000 Aventine Dr Apt. 403 City Arden State NC Zip 28704

Home Tel.( ) Cell.(520) 280-6659 Have you ever been a patient of our practice? ❑ Yes ☑ No

Referred By Nicole (FIRST NAME) Sullens (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ☑ No

Dentist Nicole (FIRST NAME) Sullers (LAST NAME) Orthodontist (FIRST NAME) (LAST NAME)

Medical Dr. (FIRST NAME) (LAST NAME) Preferred Pharmacy Ingles Pharmacy Tel.(828) 684-9019

Driver's Lic.# None Nearest relative not living with you Kori (FIRST NAME) Adkins (LAST NAME) Tel.(623) 466-4298

Employer Investigative Professionals LL Bus. Tel.(928) 451-1598 Personal Payment Type: ❑ Cash ❑ Check ☑ Credit Card

In case of emergency, please contact Joseph Hoover Tel. (928) 451-1598 Relation Husbank

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

☑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other

Name Elizabeth (FIRST NAME) Adkins (LAST NAME) S.S.# 416-72-9001 Birth Date 09/03/1949 Age 71

Tel.( ) Cell. (520) 280-6659 E-mail anni@anniadkins.com

Street 1000 Aventine Dr Apt. 403 City Arden State NC Zip 28704

Driver's Lic.# None Employer Investigative Professionals LLC Bus. Tel.(928) 451-1598

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

Name Joseph (FIRST NAME) Hoover (LAST NAME) Relation Husband S.S.# 446-36-5713 Birth Date 02/03/1940

Street 1000 Aventine Dr Apt. 403 City Arden State NC Zip 28704

Tel. (928) 451-1598 Employer Investigative professionals LLC Bus. Tel.(928) 451-1598

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ☑ Not . . . . . School Name and Address (SCHOOL NAME) (ADDRESS)

Marital Status: . ☑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated (CITY) (STATE) (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ☑ Not . . . . . Do you belong to a PPO or HMO? ❑ Yes ☑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer Investigative Professionals LLC

Bus. Address (ADDRESS) (CITY) (STATE) (ZIP)

Bus. Tel.(928) 451-1598 Plan

Ins. Co. Name I.D. #

Address (ADDRESS) (CITY) (STATE) (ZIP)

Tel.( ) Group Name

Group # Insured Party Elizabeth (FIRST NAME) Adkins (LAST NAME)

Relation Birth Date 09/03/1949 Sex: ❑ M ❑ F

S.S. # 416-72-9001 Tel.( )

Address 1000 Aventine Dr (ADDRESS) Arden (CITY) NC (STATE) 28704 (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer AARP Medicare Advantage

Bus. Address PO Box 31362 (ADDRESS) Salt Lake C (CITY) UT (STATE) 84131 (ZIP)

Bus. Tel.(800) 643-4845 Plan 911-87726-04

Ins. Co. Name I.D. #

Address (ADDRESS) (CITY) (STATE) (ZIP)

Tel.( ) Group Name

Group # Insured Party Elizabeth (FIRST NAME) Adkins (LAST NAME)

Relation Birth Date 09/03/1949 Sex: ❑ M ❑ F

S.S. # 416-72-9001 Tel.( )

Address 1000 Aventine Dr (ADDRESS) Arden (CITY) NC (STATE) 28704 (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer

Bus. Address (ADDRESS) (CITY) (STATE) (ZIP)

Bus. Tel.( ) Plan

Ins. Co. Name I.D. #

Address (ADDRESS) (CITY) (STATE) (ZIP)

Tel.( ) Group Name

Group # Insured Party (FIRST NAME) (LAST NAME)

Relation Birth Date Sex: ❑ M ❑ F

S.S. # Tel.( )

Address (ADDRESS) (CITY) (STATE) (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer

Bus. Address (ADDRESS) (CITY) (STATE) (ZIP)

Bus. Tel.( ) Plan

Ins. Co. Name I.D. #

Address (ADDRESS) (CITY) (STATE) (ZIP)

Tel.( ) Group Name

Group # Insured Party (FIRST NAME) (LAST NAME)

Relation Birth Date Sex: ❑ M ❑ F

S.S. # Tel.( )

Address (ADDRESS) (CITY) (STATE) (ZIP)

HEALTH HISTORY:

Patient Name Elizabeth Adkins

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? referal for tooth extraction

		Yes	No
1.	***Height*** 5 ft ***Weight*** 155 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*** 04/01/2020	☑	☐
	If so, for what are you being treated? Anual Physical and Flu Shot		
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?	☑	☐
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☑
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. Hay fever / sinus problems?		✔	
24. Snoring?		✔	
25. Sleep apnea / CPAP?		✔	
26. Difficult breathing / other lung trouble?	✔		
27. Tuberculosis?		✔	
28. Emphysema?		✔	
29. Do you smoke or vape? If so, how much a day_____		✔	
30. Do you use chewing tobacco?		✔	
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 ulcer / acid reflux?		✔	
51. Contagious diseases?		✔	
52. Sexually transmitted diseases?		✔	
53. Problems with immune system? Possibly from medication / surgery, etc.		✔	
54. Delay in healing?		✔	
55. A tumor or growth?		✔	
56. Cancer / radiation therapy / chemotherapy?	✔		
57. Chronic fatigue / night sweats?		✔	
58. Are you on a diet?		✔	
59. A history of alcohol abuse?		✔	
60. A history of marijuana or other drug use?		✔	
61. Contact lenses?		✔	
62. Eye disease / glaucoma?		✔	
63. Mental health problems / anxiety / depression?		✔	
64. A removable dental appliance?		✔	
65. Pain or clicking of jaws when eating?		✔	

WOMEN ONLY: *(QUESTIONS 66–69)*

Patient Name Elizabeth Adkins

	Yes	No
66. Is there a possibility of pregnancy?	❑	☑
67. Expected delivery date? _____		
68. Are you nursing?	❑	☑
69. 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
70. Any kind of medication, drug, pills?	✔		
71. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Xarelto, Eliquis, Fish oil)?		✔	
72. Have you ever taken diet pills?		✔	
73. Any natural product, herbal supplement or homeopathic remedy?		✔	
74. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Prolia, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, or Evista in the past 12 years?		✔	

75. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

76. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ❑ Methadone ❑ Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other _____

Treating doctor: _____

77. Please list any medications you are currently taking:

Medication	Dosage	Frequency
cephalexin	500 mg	4 x day

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ☑ No

Who is driving you home? Joe Hoover

Is there any condition concerning your health that the Doctor should be told about? ☑ Yes ❑ No – If Yes, describe

Brain Raditation

Do you wish to speak to the Dr. privately about anything? ❑ Yes ☑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
78. Local anesthetic (numbing meds.)?		✔	
79. Penicillin?	✔		
80. Other antibiotics?		✔	
81. Sulfa drugs?		✔	
82. Sodium pentothal / Valium /other tranquilizers?		✔	
83. Aspirin?		✔	
84. Amoxicillin?		✔	
85. Codeine or other narcotics?		✔	
86. Latex?		✔	
87. Soy?		✔	
88. Eggs / yolk?		✔	
89. Sulfites?		✔	
90. Do you have any known allergies?		✔	

91. Please list any allergies other than drug allergies:

Penicillan

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

Medication / Antibiotic Name

Is there a family history of:

☑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ☑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

Patient Name Elizabeth Adkins

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.

X Elizabeth A Adkins	X 9/18/2020	X	X
Signature of patient *(Parent or Guardian if Minor)*	**Date**	**Reviewed by**	**Date**

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.

X Elizabeth A Adkins	X 9/18/2020
Signature of patient *(Parent or Guardian if Minor)*	**Date**

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.

X Elizabeth A Adkins	X 9/18/2020
Signature of patient: *(Parent or Guardian if Minor)*	**Date**

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. I permit messages to be left on my phone and / or mobile phone concerning my appointment

❑ I permit the office to communicate with me via text message on my cell phone.

X Elizabeth A Adkins	X	X 9/18/2020
Signature of patient *(Parent or Guardian if Minor)*	**Doctor**	**Date**

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.

X Elizabeth A Adkins	X 9/18/2020
Signature of patient *(Parent or Guardian if Minor)*	**Date**