MURPHY ORAL & MAXILLOFACIAL SURGERY

ARIC A. MURPHY, DDS, MD

COVID-19 PANDEMIC

DENTAL TREATMENT NOTICE, ACKNOWLEDGEMENT OF RISK & DISCLOSURES

_____

Patient's Name

	YES	NO
Have you **HAD COVID-19** or tested **POSTIVE** for **COVID-19**? [If you tested **POSITIVE** have you received clearance from isolation by the State?]	☐ ☐	☐ ☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
In the past week have you been in contact with someone who tested positive for COVID-19?	☐	☐
Do you otherwise feel unwell, have a cough, or runny nose, reduction in your sense of smell?	☐	☐
Do you have a flu-like symptoms, muscle pain, fever or above normal temperature?	☐	☐

COVID-19, "Corona virus" has been classified as a pandemic. It is highly contagious virus 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 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 this office. Oral Surgery procedures cause an "aerosol" (particles in the air) which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and create a risk of exposure. During treatment you are not able to wear a protective mask, 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 & unrelated to my visit here.

By signing this document, I acknowledge that I have read and understand the information stated above and 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

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HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy of contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review the Notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient my revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Patient Name: _____

May we leave a message with more detailed health and or financial information on your cell phone and or home phone? Yes No

May we discuss your medical procedure, health history and or financial information with any other member of your family? Yes No

If YES, please name the members allowed: _____

This Consent is signed by: _____
Name of Patient or Representative (PLEASE PRINT NAME)

Signature & Date: _____

Relationship to Patient if other than patient: _____

Practice Representative Signature (Witness): _____

__ *Patient refused to sign.*
__ *Due to an emergency situation it was not possible to obtain an acknowledgement.*
__ *Other:* _____

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ARIC A. MURPHY, DDS, MD

Date: _____

First Name_____ MI___ Last Name_____

Gender: ◯ Female ◯ Male ◯ Other

Date of Birth _____/____/_____ Age_____ SS#_____

Primary Phone # _____ Email Address _____

Preferred Method of Contact ◯ Text ◯ Phone ◯ Email

Home Address_____

City, State, Zip_____

Referring Doctor / Dentist _____

Pharmacy (and location) _____

Emergency Contact (Name & Number) _____ Relationship: _____

RESPONSIBLE PARTY FOR YOUR ACCOUNT ( ) Self ( ) Parents/Guardian ( ) Other

Parent/Guardian Name (First & Last) _____

Date of Birth _____/____/_____ SS# (required) _____

Primary Phone # _____ Email Address _____

Driver License Number: _____ Employer (Required) _____

Address_____

DENTAL INSURANCE: (Or a COPY of your insurance card)

Insurance Company Name: _____ Effective Date: _____

Name of Insured Party: _____

Member ID or SS #: _____

Insured Date of Birth: _____

Group#_____

If Requested –MEDICAL INSURANCE : (Or COPY of card)

Insurance Company Name: _____

Member ID or SS #: _____

MURPHY ORAL & MAXILLOFACIAL SURGERY

ARIC A. MURPHY, DDS, MD

Name:_____ Date:_____

Date of Birth: _____ Sex: M / F Height:_____Weight: _____

Your answers are for our records only and will be kept confidential.

Main Concern you would like addressed by the Doctor:_____

1. Do you have any **Medical Problems**?..... Yes No
   If so please list: _____
2. Do you have any **Allergies to Medications (or egg products or soy products)**? ..... Yes No
   If so, please list: _____
3. Do you have **Asthma**?..... Yes No
   If so, rate severity: mild/moderate/severe; If you use an inhaler please list medication:_____
4. Do you **Smoke or VAPE**?..... Yes No
5. Have you had an **Artificial joint replacement** (knee, hip, shoulder, etc.)? ..... Yes No
6. Are you **currently taking any Medications** (including vitamins or homeopathic medications)?..... Yes No
   If YES please list, and list dose if known:

   _____

   _____

   Have you ever taken **Bisphosphonates** for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia) ? ..... Yes No
7. Are you now under the care of a physician?..... Yes No
   If you know the name of your physician please list: _____
8. **Do you have any of the following diseases or problems**?
   a. Damaged heart valves, artificial valves or heart murmur..... Yes No
   b. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition..... Yes No
      1. Chest pain upon exertion?..... Yes No
      2. Shortness of breath after mild exercise? ..... Yes No
      3. Do your ankles swell?..... Yes No
   c. Hay fever..... Yes No
   d. Fainting spells or seizures..... Yes No
   e. Diabetes (Type I / Type II) ..... Yes No
   f. Hepatitis, jaundice or liver disease ..... Yes No
   g. Thyroid problems..... Yes No
   h. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
   i. Arthritis or painful, swollen joints including jaw joint (TMJ)..... Yes No
   j. Osteoporosis ..... Yes No
   k. Stomach ulcer or hyperacidity ..... Yes No
   l. Kidney trouble ..... Yes No
   m. Tuberculosis..... Yes No
   n. Persistent cough or cough that produces blood..... Yes No
   o. Persistent swollen neck glands..... Yes No
   p. Low blood pressure..... Yes No
   q. Epilepsy or neurological disorder..... Yes No
   r. Cancer ..... Yes No
   s. Any disease, drug or transplant operation that has depressed your immune system..... Yes No
9. Have you had abnormal bleeding?..... Yes No

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10. Do you have any **blood/bleeding disorder** such as anemia? ..... Yes No
11. Have you ever had treatment for a tumor or growth? ..... Yes No
12. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
13. Are you **ALLERGIC to or had a reaction to** (if so, please briefly explain):
    a. **Local anesthetics** ..... Yes No
    b. **Penicillin** ..... Yes No
    c. Sulfa drugs or **Other antibiotics (please list_____)** ..... Yes No
    d. **Barbiturates or sleeping pills** ..... Yes No
    e. **Aspirin** ..... Yes No
    f. Iodine ..... Yes No
    g. **Codeine or other narcotics (Vicodin, Percocet…)** ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. **Egg Allery** ..... Yes No
    j. **Soy Bean / Soy Oil Allergy** ..... Yes No
    k. Other ..... Yes No
14. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
    _____
15. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain: _____
16. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes No
17. Are you wearing contact lenses? ..... Yes No
18. Are you wearing removable dental appliances? ..... Yes No
19. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

1. Are you pregnant or trying to become pregnant ..... Yes No
2. Do you have problems associated with your menstrual period (such as heavy bleeding)? ..... Yes No
3. Are you nursing? ..... Yes No
4. Are you taking birth control pills (antibiotics, if used, can decrease efficacy of pills)? ..... Yes No

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____