COVID-19 PANDEMIC DENTAL TREATMENT

NOTICE AND ACKNOWLEDGEMENT OF RISK

_________________________________ _________________

Patients Name Date of Birth

The World Health Organization has characterized the COVID-19 virus, also known as the "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 be impossible 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.
I have read and understand the information stated above:

_________________________________ _________________

Patient or Legal Representative Signature Date

____

Print Patient or Legal Representative Name/Relationship

_________________________________ _________________

Witness Signature (optional) Date

Revised May 15, 2020

R. BRYAN GULLEY, D.D.S.
JESUS A. GOMEZ, D.D.S

ORAL & MAXILLOFACIAL SURGERY

6421 Saratoga Bldg. 101 - Corpus Christi, TX 78414

PATIENT INFORMATION

Name: ______________________ ☐ Male ☐ Female Emergency Contact: ______________________

☐ Single ☐ Married ☐ Child ☐ Other Birth date: ___ / ___ / ___ Age: ______ S.S.#: ______________________

Home Address: ______________________ City ____________ State ____ Zip ______

Home Phone: (___) ______________ Work: (___) ______________ ext. ________

Cell: (___) ______________ Driver's License State and #: ______________________

Employer: ______________________ Occupation: ______________________

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as above Name:. ______________________ Birth date: ___ / ___ / ___ Relation: ______________

Billing Address: ______________________ City ____________ State ____ Zip ______

Home Phone: (___) ______________ Work: (___) ______________ S.S. #: ______________________

Employer: ______________________ Occupation: ______________________

Signature: ______________________

INSURANCE INFORMATION

Medical Insurance

Insurance Co. Name: ______________________ Phone: (___) ____________ Group/Policy #: __________

Insured's Name: ______________________ Insured's Birth date:___ / ___ / ___ Relation: __________

Insured's Social or Unique ID: ______________________ Insured's Employer: ______________________

Insured Address if Different than Patient: ______________________________________

Dental Insurance

Insurance Co. Name: ______________________ Phone: (___) ____________ Group/Policy #: __________

Insured's Name: ______________________ Insured's Birth date:___ / ___ / ___ Relation: __________

Insured's Social or Unique ID: ______________________ Insured's Employer: ______________________

Insured Address if Different than Patient: ______________________________________

I hereby authorize payment of the insurance benefit
otherwise payable to me to be paid directly to this office: ______________________

Responsible Party Signature

Please indicate method of payment of today's visit:
☐ Check ☐ Cash ☐ Credit Card

Please Note: Our fees are payable in full for first office exam, and at time of the surgical appointment. If you have any question about this policy, please contact our secretary.
Thank You.

IN THE EVENT OF DEFAULT, I AGREE TO PAY REASONABLE COLLECTION CHARGES AND ATTORNEY FEES.

____
Responsible Party Signature

I acknowledge I am fully responsible for all fees charged regardless of my insurance coverage.

____
Acknowledgement Signature

Today's Date: ____________

Patient Name: ____________ Patient's Employer: ____________ Dentist/Referred by: ____________

Birth date: ____/____/____ Age:______ ☐ Male ☐ Female Height:______ Weight:______

Spouse's Name____________ Spouse's Employer____________

PLEASE ANSWER ALL QUESTIONS AND FILL IN BLANK SPACES WHERE INDICATED. ANSWERS TO THE FOLLOWING ARE ONLY FOR OUR RECORDS AND WILL BE CONSIDERED CONFIDENTIAL.

1. Have you had food or drink today?................. ☐ Yes ☐ No
2. Are you in good health?.................................. ☐ Yes ☐ No
3. Are you under the care of a Physician?........... ☐ Yes ☐ No
4. Your last Physical Examination was on? ____________
5. Name and Phone of your Physician:

____

6. Have you had any illness, operation or been Hospitalized? .... ☐ Yes ☐ No
7. Do you drink alcoholic beverages? .... ☐ Yes ☐ No
8. Do you smoke or use Tobacco products? .... ☐ Yes ☐ No
9. Do you take Vitamins or Supplements? .... ☐ Yes ☐ No
10. Have you had abnormal bleeding associated with previous extractions, trauma or surgery?..................... ☐ Yes ☐ No
11. Do you have any bleeding disorder such as anemia?.............................. ☐ Yes ☐ No
12. Are you taking any drugs or medications?..... ☐ Yes ☐ No
    If "Yes" what medications ____________

____
____
____
____
____
____

13. Are you taking any of the following? .... ☐ Yes ☐ No
    a. Antibiotics or Sulfa Drugs .... ☐ Yes ☐ No
    b. Anticoagulants (blood thinners)................. ☐ Yes ☐ No
    c. Medicine for high blood pressure............... ☐ Yes ☐ No
    d. Cortisone (steroids)..................................... ☐ Yes ☐ No
    e. Tranquilizers .... ☐ Yes ☐ No
    f. Aspirin .... ☐ Yes ☐ No
    g. Insulin, Tolbutamid or Metformin................. ☐ Yes ☐ No
    h. Digitalis or drugs for heart problems .... ☐ Yes ☐ No
    i. Nitroglycerin .... ☐ Yes ☐ No
    j. Are you taking OR have you ever taken Bisphosphonates (Fosamax, Actonel, Aredia, Boniva, Didronel, Skelid, Bonefos or Zometa) for Osteoporosis or Chemotherapy for multiple Myeloma etc? .... ☐ Yes ☐ No
    k. Fen-Phen (now or in the past) or related drugs such as Ionimim, Adipex, Phentramine, Fastin, Pondimin (fenfluramine) and Redux (dexfenfluramine)............................... ☐ Yes ☐ No
    l. Other not listed above ____________

14. Please answer the following with a YES or NO.
    A. Do you grind your teeth at night................ ☐ Yes ☐ No
    B. Do you have a history of jaw pain with opening & closing .... ☐ Yes ☐ No
    C. Does your jaw pop or click......................... ☐ Yes ☐ No
    D. Has your jaw ever been stuck open or closed ☐ Yes ☐ No
15. Have you had Radiation or Chemotherapy.... ☐ Yes ☐ No
16. Are you pregnant .... ☐ Yes ☐ No
17. Are you allergic or have you reacted adversely to:
    A. Iodine .... ☐ Yes ☐ No
    B. Penicillin or other Antibiotics..................... ☐ Yes ☐ No
    C. Sulfa Drugs .... ☐ Yes ☐ No
    D. Barbiturates, sedatives, sleeping pills........ ☐ Yes ☐ No
    E. Aspirin or Tylenol.. ☐ Yes ☐ No
    F. Soybeans or Eggs .... ☐ Yes ☐ No
    G. Latex.. ☐ Yes ☐ No
    H. Local Anesthetics....................................... ☐ Yes ☐ No
    I. Other ____________
18. Have you had an adverse reaction associated with previous dental or medical treatment .... ☐ Yes ☐ No
19. Have you had or currently have any of the following illnesses?
    **please answer yes or no to all of the following items below*:

Illness	Yes	No
AIDS or HIV Positive	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Angina or chest pain	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Artificial Joint replacement	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
COPD, Emphysema, lung disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Hepatitis, A, B, C	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Low Blood pressure	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Liver problems	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Heart Valve replacement or bypass	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Venereal Disease (STD's)	☐ Yes	☐ No
Stroke or TIA	☐ Yes	☐ No

Other ____________

I have filled out this health questionaire completely. I have advised you of all medical problems of which I am aware.

____
Patient Signature Date

I have reviewed the health history form above:

____
Doctor Signature Date

GULLEY ORAL & MAXILLOFACIAL SURGERY
DENTAL IMPLANT CENTER
R. BRYAN GULLEY, DDS & ASSOCIATES

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.Please review it carefully.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

- Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation and treatment
- Your health information may be used for the purposes of obtaining payment
- Your health information may be used as necessary to support the day to day activities and management of this practice.
- Your health information may be disclosed if mandated by law.
- Your health information may be disclosed to public health agencies as required by law.

OTHER USES AND DISCLOSURES REQUIRE YOUR SPECIFIC WRITTEN AUTHORIZATION

YOUR RIGHTS:

You have certain rights under the federal privacy standards. These include.

- The right to request restrictions on the use and disclosure of your health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your health information.
- The right to amend or submit corrections to your health information.
- The right to receive an accounting of how and to whom your health information has been disclosed.
- The right to receive printed copy of this notice.

OUR DUTIES:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

FURTHER INFORMATION:

For further information regarding our privacy practices please contact a member of our staff at (361) 992-3873, correspondent to the following address:
Attention Privacy Officer
6421 Saratoga Blvd. Bldg. 101
Corpus Christi, TX 78414

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for

R. Bryan Gulley, DDS &
Jesus A. Gomez, DDS
6421 Saratoga Blvd., Building 101
Corpus Christi, Texas 78414

____
Name of Patient (type or print)

____
Patient or Patient Representative Signature

____
Date

____
Relationship of Patient Representative to Patient

Above — Patient or Representative Use Only

Below — Provider User Only

Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

Patient refused to sign the Privacy Notice Acknowledgement

Patient was unable to sign because: ______________________________

There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.

____
Employee Signature

____
Date

Due to the state regulations the following information will be required for anyone to receive narcotic pain prescriptions and they must be sent electronically.

Name

____

Address

____

SSN

____

Pharmacy Name

____

Pharmacy Address

____