COVID-19 Treatment Consent Form

I consent to receive treatment from Gillum Dentistry during the COVID-19 outbreak. I understand there is much to learn about the newly emerged COVID-19 including how it spreads and is transmitted. I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contact. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time. Or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious. I understand that due to the unknowns of this virus, the number of other patients that will be in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment within the practice. I understand that Gillum Dentistry follows the recommended CDC guidelines for reducing the risk of COVID-19 in the dental setting. Our foremost goal is to keep our patients and staff safe from COVID-19. I understand that dental procedures have the potential to include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 may be spread.

I understand that the symptoms listed below are partially representative of COVID-19:

- Fever
- Dry Cough / Sore Throat
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

I confirm that I do not display or currently have any of the symptoms that are representative of COVID19, which are outlined above: Initial ( ) I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival. I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. Initial ( ). I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days Initial ( ).

Patient Name:_____

Patient/Guardian Signature:_____

Date:_____

For Practice Use:
Witness Signature:_____ Date:_____

Patient Information

Date _____

Patient Name _____ E-Mail _____

Address _____City _____State _____ Zip _____

Phone Number_____ Height _____ Weight _____

Date of Birth _____Social Security# _____

How did you hear about our office? _____

Responsible Party Information

Name _____ e-Mail _____

Address _____City _____State_____ Zip_____

Home Phone _____ Work Phone _____Cell Phone _____

Date of Birth _____ Social Security# _____Relationship _____

Employer _____Occupation _____ # of Years _____

Spouse _____Relationship _____

Date of Birth _____ Social Security# _____Work Phone _____

Employer _____ Occupation _____# of Years _____

Insurance Information

Insured's Name _____ Social Security# _____

Insurance Company _____Group#_____Phone# _____

Address for Dental Claims _____

Do you have a second Dental Insurance? _____

Insured's Name _____ Social Security# _____

Insurance Company _____Group#_____Phone# _____

Address for Dental Claims _____

Emergency Information

Name of nearest Relative not living with you? _____ Phone _____

Address _____City_____State _____ Zip _____

Signature _____

New Patient Health/Dental History

Date: _____

Full Name _____ DOB:_____

How did you hear about us?

[ ] A personal friend [ ] Family member [ ] Co-worker recommended your practice.
[ ] My doctor recommended you [ ] by my employer
Whom may we thank? _____
[ ] I chose from a list of insurance providers provided
[ ] I found your practice with _____ an online search engine
[ ] I Walked in/drove by

What expectations do you have that we must fulfill?_____
_____
What should we do different than your last dental office?_____
_____
Would you like to change the way your teeth look? _____
_____
What would you like us to do for you today?_____
_____

Have you had or do you have the following:

_____ Any Heart Condition
_____ Mitral Valve Prolapse
_____ Rheumatic Fever
_____ Heart Murmur
_____ Heart Attack
_____ Bypass Surgery
_____ Angina
_____ Angioplasty/Stents
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Sinus Problems
_____ Ear Problems
_____ Kidney Problems

_____ HIV+ ____ AIDS ____ HPV
_____ Blood Transfusion
_____ Hepatitis A or B or C
_____ Hospitalized in last 2 yrs.
_____ Surgery
_____ Prosthetic Joints
_____ Venereal Disease
_____ Apthus Ulcers
_____ Cold Sores
_____ Orthodontics
_____ Tuberculosis
_____ Chronic Heart Failure
_____ Require Antibiotics before treatment _____

_____ Nervous Problems
_____ Hyperactivity
_____ Depression
_____ Epilepsy
_____ Asthma
_____ Diabetic
_____ Cancer
_____ Radiation Treatment
_____ Chemo Therapy
_____ Trauma to Teeth or Jaw
_____ Anxious about dentistry
_____ Pregnant?

1. Have you ever been diagnosed with Sleep Apnea? [ ] Yes [ ] No

2. Have you ever had an overnight sleep study? [ ] Yes [ ] No Date _____

3. Have you been told that you gasp for air or stop breathing while sleeping? [ ] Yes [ ] No

4. Do you snore? [ ] Yes [ ] No [ ] It disrupts my bed partner

5. Do you or have you used a CPAP? [ ] Yes [ ] No

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1. Have you noticed a change in your bite? [ ] Yes [ ]No

2. Are you aware of any of the following? Popping/Clicking/Noise in jaw joints [ ] Yes [ ] No

3. Do you have difficulty or pain [ ] opening wide [ ] chewing

4. Do you grind or clench your teeth? [ ] at night [ ] during the day [ ] when stressed

5. Do you experience pain in your: [ ] Jaw [ ] Face [ ] Neck [ ] Shoulders

6. When you wake up, do your jaw joint or muscles feel tight or sore [ ] Yes [ ] No

7. Do you get [ ] headaches [ ] morning headaches [ ] migraines

8. Have you ever had a [ ] car accident [ ] trauma to your head/face

9. Do you restrict or avoid normal activities due to pain or symptoms? [ ] Yes [ ] No

Please list any other health concerns: _____

_____

Are you allergic to (circle): Penicillin Codeine Local Anesthetic Other _____

Are you taking any medications now? Names: _____

_____

Name of Primary Care Physician: _____

I hereby authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the above patient, and further authorize the Doctor to employ such assistance, as he deems necessary and appropriate. I understand that, prior to treatment; full explanation of the procedures involved will be given by the Doctor/Staff. I agree to pay for all services rendered by this office, and in the case of delinquency I agree to pay all reasonable collection costs, including attorney fees.

_____

Signature of patient or responsible party, if patient is under 18 years of age Date

_____

Relationship to patient Date

Richard S. Gillum D.D.S.
1259 N. State Rd. 135, Suite E
Greenwood, IN 46142
317-888-7576

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that under the Health Portability & Accountability Act of 1996 ("HIPPA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Richard S. Gillum, D.D.S.
1259 IN - 135, Suite E
Greenwood, IN 46142
317-888-7576

General Consent for Dental Services

Once discussed with me in advance, I herby authorize recommended treatment and or procedure(s) determined by Dr. Gillum

Assignment of Benefits

I herby authorize, request, and assign payment directly to Dr. Gillum covering this period of treatment and related past and future treatments, by all insurance carriers with whom I have coverage.

Payment Guarantee

All professional services rendered are charged to the patient or financially responsible party. As a courtesy to you, we will file all claims to your insurance company. All services rendered must be paid in full at the time of service, until your deductible has been met, you must pay all co-pays or percentages as dictated by your insurance carrier. If you have no insurance, you must pay in full at the time of service, unless prior arrangements have been made. Your insurance policy is a contact between you and your insurance company. If your insurance company has not paid your account in full within 60 days, you will be responsible for the remaining charges and we will continue to assist you in resolving the balance. I understand and agree that I am solely responsible for all charges to my account. I agree to pay all collection costs, returned check fees, attorney fees and court costs incurred by Dr. Gillum in the collection of all sums due.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Cancellation Policy

Unless cancelled at least 24 hours in advance, a fee will be accessed. (Not billable to any insurance company.) Cancellation fees will range from $25.00-$50.00. Third and or successive appointments canceled without acceptable notice, will be charged double the rates listed above. Please help us serve you better by keeping scheduled appointments.

Print Patients Name _____

Signature of Patient or Responsible Party _____ Date _____