WELCOME

encore DENTISTRY
Nancy V. Cabansag, DDS

PATIENT INFORMATION

First Name: _____ Middle Initial: _____

Last Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____

Sex ◯ Male ◯ Female

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Date of Birth: _____ Social Security Number: _____

Email: _____

PATIENT SCREENING

Do you/they have fever or felt hot or feverish recently?	Yes	No
Are you/they having shortness of breath or other difficulties breathing?	Yes	No
Do you/they have a cough?	Yes	No
Any other flu-like symptoms, headache or fatigue?	Yes	No
Have you/they experienced recent loss of taste or smell?	Yes	No
Are you/they in contact with any confirmed COVID-19 positive patients?	Yes	No
Do you/they have heart, lung or kidney disease?Auto-immune disorders?	Yes	No
Have you traveled in the past 14 days outside of the DFW area?	Yes	No

HOW DID YOU HEAR ABOUT US?

◯ Welcome Wagon ◯ Hwy 287 Billboard

◯ Money Mailer ◯ Web Search

Other: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____

MEDICAL HISTORY

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PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following? ***(Please only mark what applies)***

AIDS/HIV Positive ◯ Yes	Cortisone Medicine ◯ Yes	Hemophilia ◯ Yes	Radiation Treatments ◯ Yes
Alzheimer's Disease ◯ Yes	Diabetes ◯ Yes	Hepatitis A ◯ Yes	Recent Weight Loss ◯ Yes
Anaphylaxis ◯ Yes	Drug Addiction ◯ Yes	Hepatitis B or C ◯ Yes	Renal Dialysis ◯ Yes
Anemia ◯ Yes	Easily Winded ◯ Yes	Herpes ◯ Yes	Rheumatic Fever ◯ Yes
Angina ◯ Yes	Emphysema ◯ Yes	High Blood Pressure ◯ Yes	Rheumatism ◯ Yes
Arthritis/Gout ◯ Yes	Epilepsy or Seizures ◯ Yes	High Cholesterol ◯ Yes	Scarlet Fever ◯ Yes
Artificial Heart Valve ◯ Yes	Excessive Bleeding ◯ Yes	Hives or Rash ◯ Yes	Shingles ◯ Yes
Artificial Joint ◯ Yes	Excessive Thirst ◯ Yes	Hypoglycemia ◯ Yes	Sickle Cell Disease ◯ Yes
Asthma ◯ Yes	Fainting Spells/Dizziness ◯ Yes	Irregular Heartbeat ◯ Yes	Sinus Trouble ◯ Yes
Blood Disease ◯ Yes	Frequent Cough ◯ Yes	Kidney Problems ◯ Yes	Spina Bifida ◯ Yes
Blood Transfusion ◯ Yes	Frequent Diarrhea ◯ Yes	Leukemia ◯ Yes	Stomach/Intestinal Disease ◯ Yes
Breathing Problem ◯ Yes	Frequent Headaches ◯ Yes	Liver Disease ◯ Yes	Stroke ◯ Yes
Bruise Easily ◯ Yes	Genital Herpes ◯ Yes	Low Blood Pressure ◯ Yes	Swelling of Limbs ◯ Yes
Cancer ◯ Yes	Glaucoma ◯ Yes	Lung Disease ◯ Yes	Thyroid Disease ◯ Yes
Chemotherapy ◯ Yes	Hay Fever ◯ Yes	Mitral Valve Prolapse ◯ Yes	Tonsillitis ◯ Yes
Chest Pains ◯ Yes	Heart Attack/Failure ◯ Yes	Osteoporosis ◯ Yes	Tuberculosis ◯ Yes
Cold Sores/Fever Blisters ◯ Yes	Heart Murmur ◯ Yes	Pain in Jaw Joints ◯ Yes	Tumors or Growths ◯ Yes
Congenital Heart Disorder ◯ Yes	Heart Pacemaker ◯ Yes	Parathyroid Disease ◯ Yes	Ulcers ◯ Yes
Convulsions ◯ Yes	Heart Trouble/Disease ◯ Yes	Psychiatric Care ◯ Yes	Venereal Disease ◯ Yes
			Yellow Jaundice ◯ Yes

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and the insurance company. Our office is not a party to that contract.

As a courtesy to you we will help you process all your insurance claims. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance to your appointment.

Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, Mastercard and Visa. Outside financing is available through CareCredit upon request and approval.

Balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

_____
Print Name of Patient or Responsible Party

_____ _____
Signature Date

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative Witness ……..

Printed Name of Patient or Legal Representative Witness ……

Date: ……..

Insurance Disclaimer

(Please read carefully)

Please note we do not accept nor participate with any DMO/HMO insurance plans.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Any treatment plan that our office proposes to you is an **estimate** of what your insurance coverage will be, it is not a guarantee. If you need **exact** payment of benefits, then a pretreatment is required. If you would like this done, you must specify to the office manager **before** any work is initiated. **(This takes 6-8 weeks).** A predetermination still does not guarantee payment.

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your insurance plan does not pay within **120 days** of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. Also remember dental insurance plans are not designed to cover all of your dental needs.

I, _____, have chosen to allow Encore Dentistry to file my insurance and accept full responsibility for this account and for all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within **120 days** of my date of service then I will become responsible to pay at that time.

Print Name: _____ **Date:** _____

Patient Signature: _____

COVID-19 PANDEMIC DENTAL TREATMENT
NOTICE AND ACKNOWLEDGEMENT OF RISK

_____ _____

Patient's Name Date of Birth

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.

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