COVID-19 ACKNOWLEDGEMENT OF RISK AND HEALTH SCREENING FORM

_____________________________________ ________________________

Patient's Name Date of Birth

Our practice wants to ensure you are aware of the relative risks of exposure to COVID-19 associated with receiving treatment. This practice has always followed the applicable state and federal regulations and recommendations regarding infection control, sterilization, disinfection, and the use of PPE (personal protective equipment). We also work to protect our patients and office staff from virus spread by promoting frequent hand washing and office cleaning, using PPE for patient encounters, and adding additional environmental controls in the treatment areas.

Although we are using enhanced infection control measures in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing during treatment or for you to wear a mask during treatment. This means that the risk of exposure to COVID-19 remains when receiving treatment during the pandemic.

COVID Health History

Have you ever been diagnosed with COVID-19?	YES	NO	If yes, when? _________
Have you ever been hospitalized for COVID-19 treatment?	YES	NO	If yes, when? _________
Are you fully vaccinated or in the course of being vaccinated for COVID-19?	YES	NO	
Have you been tested for COVID-19 and are awaiting results?	YES	NO	
In the last 14 days, have you been in contact with any confirmed cases of COVID-19?	YES	NO	

Symptoms – Today, or in the last 14 days:

Have you had a fever or felt hot or feverish?	YES	NO
Have you had any shortness of breath or other breathing difficulties?	YES	NO
Have you had a cough?	YES	NO
Have you had any other flu-like symptoms, such as an upset stomach, headache, or fatigue?	YES	NO
Have you had a loss of taste of smell?	YES	NO
Have you otherwise felt unwell?	YES	NO

Patient Acknowledgement - By signing this document, I acknowledge that I have read the Patient Acknowledgment and that I understand and accept that there is a risk of COVID-19 exposure with treatment. I also acknowledge that the Health History and Health Screening answers I have provided are true and accurate.

___________________________________ ____________

Patient or Legal Representative Signature Date

____

Print Patient or Legal Representative Name/Relationship

______________________________ ____________

Witness Signature Date

WisNova
INNOVATIVE DENTAL SPECIALISTS
ENDODONTICS • ORAL SURGERY • PERIODONTICS

Patient Name:	DOB: / /	Sex:	
Address:	City:	State:	Zip:
Phone #(CELL):	Phone #(HOME):	Email:	
Employer:	Social Security #: - -		
General DDS:	Medical Dr.:	Referring Dr.:	
Have you or a family member previously been seen at our office?:			
Emergency Contact Name & Phone #:			
Reason for today's visit:			
Insurance information:			
Primary Dental	Secondary Dental	Primary Medical	Secondary Medical
Employer:	Employer:	Employer:	Employer:
Insurance Company:	Insurance Company:	Insurance Company:	Insurance Company:
ID#:	ID#:	ID#:	ID#:
Group#:	Group#:	Group#:	Group#:
Insured Information: First Name: Last Name: DOB: / / SS#: - - Relationship to patient:	Insured Information: First Name: Last Name: DOB: / / SS#: - - Relationship to patient:	Insured Information: First Name: Last Name: DOB: / / SS#: - - Relationship to patient:	Insured Information: First Name: Last Name: DOB: / / SS#: - - Relationship to patient:
Parent/Guardian information if patient is a minor:			
Name:	DOB: / /	Marital Status:	Employer:
Cell Phone:	Home Phone:	Email:	Social Security #:
Name:	DOB: / /	Marital Status:	Employer:
Cell Phone:	Home Phone:	Email:	Social Security #:
*If parents/guardians are divorced, who is primary for insurance?			

Authorization:

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any chances in myself or child's medical and dental status. I authorize release of any information to insurance carriers and to other health care providers involved in myself or child's care. I authorize WisNova to perform any necessary dental services that are needed during diagnosis and treatment.

I accept full responsibility for all treatment performed at WisNova. I understand that payment is expected at the time services are rendered. I understand that insurance coverage is a contractual agreement between my insurance company and myself. A plan is not a guarantee of payment, it often does not cover all costs involved in treatment. I understand that should my account become past due, I will be responsible for all fees, interest charges, late charges and all costs of collections.

Responsibility Party Signature:___________________________________Date:__________________________

WisNova

INNOVATIVE DENTAL SPECIALISTS

ENDODONTICS • ORAL SURGERY • PERIODONTICS

Health History Form

Patient's Name ______________________________________ Date of Birth __________________________

Gender: Male / Female Height: __________ Weight: __________

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Medical Doctor: ____________________________ Phone: ________________ Date of last physical exam _______________

MEDICAL HISTORY

Do you have or have you ever had (CIRCLE SPECIFIC CONDITION): ☐ **NONE**

High blood pressure	Defibrillator	Asthma	Osteoporosis/osteopenia
Previous heart attack	Kidney disease	Emphysema	Sinus infections
Stents in heart arteries	Kidney failure/dialysis	COPD	TMJ problems
Stents in other blood vessels	Liver disease	Sleep Apnea	Dementia
Heart murmur	Cirrhosis	Snoring	Alzheimer's
Heart valve replacement	Hepatitis	Tuberculosis	Parkinson's disease
Heart valve problem	Stroke	Bleeding disorder	Developmental Delay
Heart failure	TIA	Lupus	Depression
Atrial fibrillation (A-fib)	Stomach/intestinal ulcers	Seizure disorder/Epilepsy	Anxiety
Arrhythmia	Diabetes	Fainting	Schizophrenia
Open heart surgery	Arthritis	Organ transplant	Bipolar Disorder
Aortic aneurysm	Joint replacement	Radiation treatment to head/neck	HIV or AIDS
Heart defect since birth	Hypothyroidism	Chemotherapy	Legally blind
Pacemaker	Hyperthyroidism	Cancer (Type: ________________)	Legally deaf

Other medical diagnoses:

____

____

SURGICAL HISTORY

Have you had general anesthesia or sedation before? Yes No

Have you or your family members had any problems with general anesthesia or sedation? Yes No
If yes, describe: ____

List any surgical procedures or operations you have had:

____

____

____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No Due Date:_____________

Health History Form

Patient's Name ______________________________________ Date of Birth _____/_________/___________

MEDICATIONS

Are you taking blood thinners: Yes No

Have you <u>ever</u> taken any of the following medications that are used for osteoporosis or bone cancer: Yes No
Alendronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Zolendronate (Reclast or Zometa), Pamidronate (Aredia), Denosumab (Xgeva or Prolia)

Please list any medications you are currently using, including weekly/monthly or injected medications: ☐ NONE

____

____

____

ALLERGIES

List any medications you are allergic to or have had an adverse reaction to: ☐ NONE

____

____

____

____

____

SOCIAL HISTORY

Do you smoke or vape? Yes No If yes, how much? ____

Do you use chewing tobacco? Yes No For how long? ____

Have you ever sought professional care or been hospitalized for:

Drug abuse? Yes No

Opioid addiction? Yes No

Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? _____________

Marijuana? Yes No How often? _____________

Recreational drugs? Yes No How often? _____________

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?_____________________________

Do you wish to talk to the doctor privately about a health related concern not listed on this form? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

____ ____

Signature of patient, parent, or legal guardian Date

____ ____

Printed name of patient, parent, or legal guardian
(Print relationship to patient if parent or guardian) Reviewing Doctor Signature (OFFICE USE ONLY)

WisNova

INNOVATIVE DENTAL SPECIALISTS

ENDODONTICS • ORAL SURGERY • PERIODONTICS

Wisconsin Consent

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's surgical care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's surgical care records to carry out treatment, payment activities, and health care operations.

Section A: Individual giving consent

***Name:____

***Patient Name:____

***Address:____

***Telephone:____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our surgical office's *Notice of Privacy Practices* accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

Section B: The uses and disclosures being authorized.

Our use of Dental Health Information: By signing this form, you will consent to our use of your surgical care records, to carry out treatment, payment activities, and health care operations as set forth in our *Privacy Practices Notice*.

Persons Involved in Care: By signing this form, you will consent to our use of your surgical care records to the following persons, including those involved in your care or payment for that care.

*****Please list person(s) you would like involved in your care or payment for that care:**

_________________________________ _________________________________

_________________________________ _________________________________

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your surgical care records to carry out treatment, payment activities, and health care operations as set forth in our *Privacy Practices Notice*, and to our disclosure of your surgical care records for disaster relief purposes as permitted by law.

Section C: Revocation:

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Officer listed below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact Officer: Joya Santarelli

Address: 5021 Washington Road, Kenosha, WI 53144

Telephone: 262-654-6770

INDIVIDUAL'S SIGNATURE

I, ___________________________________, have had full opportunity to read and consider the contents of this consent. I understand that by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

***Signature____ Date_______________________________

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following:

***Personal Representative/Parent Name:____

***Relationship to Individual:____

WisNova Innovative Dental Specialists

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _______________________________, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: ______________________________________

Signature: ____

Date: ____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

____
____
____

2002 American Dental Association

All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).