

COVID-19 QUESTIONNAIRE

PATIENT DISCLOSURES:

Patient Name _____

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced shortness of breath or had trouble breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a dry cough?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a runny nose?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost or had a reduction in your sense of smell or taste?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a sore throat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in contact with someone who has tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been tested for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
If so, have you tested <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Awaiting Results		
Have you traveled outside the United States by air or cruise ship in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled within the United States by air, bus or train within the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

X _____ **X** _____ **X** _____
Signature of patient (Parent or Guardian if Minor) Witness Date

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

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.

X _____ **X** _____ **X** _____
Signature of patient (Parent or Guardian if Minor) Doctor Date

WELCOME TO OUR PRACTICE

PATIENT INFORMATION...

Date 01/05/2021

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____
Sex: Male Female Birth Date _____ Age _____ Social Security Number _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Home Tel.(_____) _____ Cell.(_____) _____ E-mail _____
Did you find our practice online? Yes No How did you hear about our office? _____ Referred By _____
Have you ever been a patient of our practice? Yes No Has a family member ever been a patient of our practice? Yes No
Dentist _____ Medical Doctor _____
Preferred Pharmacy _____ Tel.(_____) _____
In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

Self (If self, skip this section) Spouse Father Mother Other _____
Name _____ S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ Relation _____ S.S.# _____ Birth Date _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION...

Marital Status: Married Divorced Widow Single Legally Separated
Employed: Full Time Part Time Retired Not

PRIMARY INSURANCE COMPANY...

Insurance Type: Dental Medical
Employer _____
Bus. Address _____ CITY _____ STATE _____ ZIP _____
Bus. Tel.(_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____ CITY _____ STATE _____ ZIP _____ Tel.(_____) _____
Group # _____ Group Name _____
Insured Party _____ Relation _____
Sex: M F Birth Date _____ S.S. # _____
Street _____ City _____
State, Zip _____ Tel.(_____) _____

SECONDARY INSURANCE COMPANY...

Insurance Type: Dental Medical
Employer _____
Bus. Address _____ CITY _____ STATE _____ ZIP _____
Bus. Tel.(_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____ CITY _____ STATE _____ ZIP _____ Tel.(_____) _____
Group # _____ Group Name _____
Insured Party _____ Relation _____
Sex: M F Birth Date _____ S.S. # _____
Street _____ City _____
State, Zip _____ Tel.(_____) _____

DENTAL INFORMATION...

Reason for today's visit _____ Are you in pain? Yes No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Discomfort, clicking, or popping in jaw | <input type="checkbox"/> Lost / broken filling(s) | <input type="checkbox"/> Stained teeth | <input type="checkbox"/> Difficulty closing jaw |
| <input type="checkbox"/> Red, swollen, or bleeding gums | <input type="checkbox"/> Teeth grinding / clenching | <input type="checkbox"/> Locking jaw | <input type="checkbox"/> Difficulty opening jaw |
| <input type="checkbox"/> A removable dental appliance | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose / shifting teeth |
| <input type="checkbox"/> Blisters / sores in or around the mouth | <input type="checkbox"/> Broken / chipped tooth | <input type="checkbox"/> Burning tongue / lips | <input type="checkbox"/> Food caught between teeth |
| <input type="checkbox"/> Prolonged bleeding from an injury / extraction | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Toothache | <input type="checkbox"/> Swelling / lumps in mouth |
| <input type="checkbox"/> Recent infections or sore throat | <input type="checkbox"/> Other | | |
| <input type="checkbox"/> My teeth are sensitive to: <input type="checkbox"/> Hot <input type="checkbox"/> Cold | | | |
| <input type="checkbox"/> Sweets <input type="checkbox"/> Biting | | | |

Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Would you like whiter teeth? Yes No

What type of toothbrush bristles do you use? Soft Medium Hard

MEDICAL HISTORY...

Are you in good health? Yes No • Are you under the care of a physician? Yes No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

Have you had any illness, operation, or been hospitalized in the past five years? Yes No

Have you ever had general anesthesia? Yes No • Have you, or a family member, had any unusual or serious reactions to general anesthesia? Yes No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

- | | | | |
|--|--|---|--|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> <input type="checkbox"/> Contagious diseases |
| <input type="checkbox"/> <input type="checkbox"/> High blood pressure | <input type="checkbox"/> <input type="checkbox"/> Intellectual / Developmental Disabilities | <input type="checkbox"/> <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> <input type="checkbox"/> Infectious mononucleosis |
| <input type="checkbox"/> <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> <input type="checkbox"/> Problems with immune system (possibly from med. / surg.) | <input type="checkbox"/> <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> <input type="checkbox"/> Delay in healing | <input type="checkbox"/> <input type="checkbox"/> Blood disorder | <input type="checkbox"/> <input type="checkbox"/> Arthritis / Joint disease |
| <input type="checkbox"/> <input type="checkbox"/> Heart murmur | <input type="checkbox"/> <input type="checkbox"/> Hay fever / Sinus problems | <input type="checkbox"/> <input type="checkbox"/> Bruise easily | <input type="checkbox"/> <input type="checkbox"/> Prosthetic implant |
| <input type="checkbox"/> <input type="checkbox"/> Chest pain / Angina | <input type="checkbox"/> <input type="checkbox"/> Snoring | <input type="checkbox"/> <input type="checkbox"/> Eye disease / Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> <input type="checkbox"/> Heart attack(s) | <input type="checkbox"/> <input type="checkbox"/> Sleep apnea / CPAP | <input type="checkbox"/> <input type="checkbox"/> Jaundice / Liver disease | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis / Osteopenia |
| <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Osteonecrosis |
| <input type="checkbox"/> <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Heart surgery | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Fainting spells | <input type="checkbox"/> <input type="checkbox"/> GI troubles / IBS / Colitis |
| <input type="checkbox"/> <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> <input type="checkbox"/> Do you smoke or vape _____
<i>If so, how much a day</i> | <input type="checkbox"/> <input type="checkbox"/> Convulsions / Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Tumor or growth |
| <input type="checkbox"/> <input type="checkbox"/> Pneumonia / Bronchitis / Chronic cough | <input type="checkbox"/> <input type="checkbox"/> Do you use chewing tobacco | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Cancer / Radiation / Chemotherapy |
| <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue / Night sweat | <input type="checkbox"/> <input type="checkbox"/> A history of marijuana or other drug use | <input type="checkbox"/> <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> <input type="checkbox"/> Are you on a diet |
| <input type="checkbox"/> <input type="checkbox"/> Trouble climbing 1-2 flights of stairs | <input type="checkbox"/> <input type="checkbox"/> A history of alcohol abuse | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Contact lenses |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | | <input type="checkbox"/> <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> <input type="checkbox"/> Other <input style="border: 1px solid black; width: 100px; height: 30px; display: inline-block;"/> |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | | <input type="checkbox"/> <input type="checkbox"/> Are you on dialysis | |
| <input type="checkbox"/> <input type="checkbox"/> Mental health problems | | <input type="checkbox"/> <input type="checkbox"/> Kidney trouble | |
| <input type="checkbox"/> <input type="checkbox"/> Anxiety | | <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases | |

MEDICATION & ALLERGIES...

Are you now taking:

- Y N**
- Blood thinners (Coumadin, Aspirin)
- Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

- | | | | |
|--|---|--|---|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Penicillin | <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> <input type="checkbox"/> Local anesthetic (numbing med) | <input type="checkbox"/> <input type="checkbox"/> Amoxicillin |
| <input type="checkbox"/> <input type="checkbox"/> Sodium pentothal / Valium / other tranq. | <input type="checkbox"/> <input type="checkbox"/> Aspirin | <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> <input type="checkbox"/> Latex |
| <input type="checkbox"/> <input type="checkbox"/> Soy | <input type="checkbox"/> <input type="checkbox"/> Eggs / Yolk | <input type="checkbox"/> <input type="checkbox"/> Sulfites | <input type="checkbox"/> <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> <input type="checkbox"/> Do you have any known allergies | | | |

Please list any other medication or antibiotic you are allergic to:

MEDICATION / ANTIBIOTIC NAME	MEDICATION / ANTIBIOTIC NAME

Please list any allergies other than drug allergies:

1-4 below for women only: (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

- 1) Is there a possibility of pregnancy? Yes No
- 2) Expected delivery date: _____
- 3) Are you nursing? Yes No
- 4) Are you taking birth control pills: Yes No

I **certify** that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____
Signature of patient (Parent or Guardian if Minor)

X _____
Reviewed by

X _____
Date

FEEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____
Signature of patient (Parent or Guardian if Minor)

X _____
Date

I hereby authorize the release of all medical/dental information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

Any payments made to the patient from the insurance company should be submitted to the office to cover the treatment rendered in the practice.

I assign all medical/dental and surgical benefits, including major medical benefits to which I am entitled to Dr. Usher and Dr. Ahghar. This assignment will remain in effect until revoked by me in writing. Photocopy of this assignment to be considered as valid as the original.

X _____
Signature of patient: (Parent or Guardian if Minor)

X _____
Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____
Signature of patient (Parent or Guardian if Minor)

X _____
Date

PHOTO CONSENT

I grant Carabelli Dental and it's representatives and employees the right to take photographs or videos of me in connection with dental treatment for education, marketing, we content or other purposes.

I **do not** grant Carabelli Dental and it's representatives and employees the right to take photographs or videos of me.



General Treatment Consent

I hereby authorize and direct the dentists and supporting personnel of Carabelli Dental to perform the explained dental treatment(s) and/or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs, and/or other diagnostic aids. These treatments and/or procedures include, but are not limited to examinations, oral prophylaxis (cleanings), scale and root plane (SRP - deep cleaning), fluoride applications, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) procedures, implant placements, tooth removal.

I agree to use local anesthesia, the use of nitrous oxide/oxygen analgesia, IV sedation depending on the judgement of the doctors.

I understand that there are advantages, disadvantages and risks involved with dental treatment(s) and hereby acknowledge that the advantages, disadvantages and risks have been explained to me. I have had an opportunity to ask questions regarding the dental treatment(s) and the advantages, disadvantages and risks. I fully understand those advantages, disadvantages and risks and accept dental treatment(s).

The dental treatment(s) I am receiving has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages, disadvantages and risks of each. I am advised that, though good results are expected, the possibility and nature of complications cannot be accurately anticipated.

I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorized and request the performance of any additional procedures that are deemed necessary or desirable.

I understand and have been informed that there are possible risks and complications associated with these dental treatment(s) and the administration of local anesthesia, nitrous oxide/oxygen analgesia, and/or IV sedation. The most common of these being swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa.

I have been given the opportunity to ask questions and give my consent for proposed treatment that will be provided at Carabelli Dental.

Patient/Guardian Signature

Witness Signature



Missed Appointment Agreement

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or canceling an appointment with less than 24 hours' notice means we are unable to fill this appointment time with another patient who needs care.

Our policy requires:

Appointment Confirmation: We will contact you five days before by text message (with your permission) and one or two days by text message or voice call before your scheduled appointment to confirm that you will be keeping the appointment. If we are unable to reach you in person, we may give your appointment to another patient.

Timely Cancellations: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a missed appointment.

On Time Arrivals: If you are more than 10 minutes late to your appointment, we may need to reschedule you for another time due to patient demand.

Compliance: Patients are only allowed three missed appointments. After the third missed appointment, you will be placed on "same day" only status for emergency needs pending receipt, review, and approval of patient letter.

Many patients use Carabelli Dental Practice's services. Your help in keeping your appointments enables us to provide better and timelier care for all our patients.

Patient/Guardian Signature



Epworth Sleepiness Scale

Patient ID #:

How Likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired?

Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0=would never dose 1=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing

SITUATION:	CHANCE OF DOZING:			
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g., theater, meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, whole stopped for a few minutes in traffic	0	1	2	3

Analyze your score interpretation: 0-7: It is unlikely that you are abnormally sleepy. 8-9: You have an average amount of daytime sleepiness. 10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention. 16-24: You are excessively sleepy and should consider seeking medical attention. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991; 14 (6):540-5.

Epworth Sleepiness Scale Score: _____/24

		Yes	No
S	Snoring: Do you snore loudly (louder than talking or louder enough to be heard through closed doors?)		
T	Tired: Do you often feel tired, fatigued or sleepy during the day?		
O	Observed: Has anyone observed you stop breathing during your sleep?		
P	Blood Pressure: Do you have or are you being treated for high blood pressure?		
B	BMI: BMI more than 35kg/m ²		
A	Age: Age over 50 years		
N	Neck Circumference: greater than 40cm (15.7 inches)		
G	Gender: Are you a male?		
TOTAL YES:			