

**Occoquan Family and Cosmetic Dentistry**  
1392 Old Bridge Road  
Woodbridge, VA 22192  
Telephone: 703-490-9094 Fax: 703-490-9096

## **Patient Advisory and Acknowledgement**

### **Receiving Dental Treatment During the COVID-19 pandemic**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please be advised that while our office complies with the State Health Department and Centers for Disease Control and Prevention with guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including our patients) could be infected, with or without their knowledge. In order to reduce the risk of spreading COVID-19, we are asking the screening questions below and we ask that you be truthful and candid in your answers.

In the past month have you experienced:

- |   |     |    |
|---|-----|----|
| 1. A fever or flu-like symptoms?                                  | YES | NO |
| 2. Shortness of breath?   | YES | NO |
| 3. Dry cough or sore throat?                                      | YES | NO |
| 4. Runny nose?  | YES | NO |
| 5. Notice a change/loss of taste or smell?                        | YES | NO |
| 6. Pink eye or conjunctivitis?                                    | YES | NO |
| 7. Have you been COVID-19 positive or being with someone who has? | YES | NO |
| 8. Have you travelled to any foreign country?                     | YES | NO |
| if so, where _____  |     |    |
| 9. Have you travelled within the United States?                   | YES | NO |
| if so, where _____  |     |    |
| 10. Have you visited a hospital?                                  | YES | NO |
| 11. Have you visited an Assisted living or Senior Center?         | YES | NO |
| 12. Have you been in a gathering of more than 10 people?          | YES | NO |

**PATIENT/RESPONSIBLE PARTY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Preferred: \_\_\_\_\_  
MI First  
Last

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (month/date/year)

Title: \_\_\_\_\_ Marital Status: single \_\_\_\_\_ married \_\_\_\_\_ separated \_\_\_\_\_ divorced \_\_\_\_\_ widowed \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City apt #  
State Zip code

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Company/Employer Name: \_\_\_\_\_ Position: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Company/Employer Name: \_\_\_\_\_

Position: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Person responsible for this account: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**FOR INSURANCE VERIFICATION PURPOSE ONLY**

Name of Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group/policy #: \_\_\_\_\_

Name of Company (employer) insurance is through: \_\_\_\_\_

Name of Dental Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Mailing Address: \_\_\_\_\_

**Insurance Assignment and Release**

I certify that I or my dependent is covered by dental insurance with \_\_\_\_\_, and assign directly to Occoquan Family and Cosmetic Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Occoquan Family and Cosmetic Dentistry may use my or my minor/child's health care information and may disclose such information to the above-mentioned insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services.

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WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

\_\_\_\_\_  
Primary Dentist: \_\_\_\_\_

In Case of emergency, who should we notify?

Name: \_\_\_\_\_ Phone (cell): \_\_\_\_\_ Phone (home): \_\_\_\_\_

## HEALTH QUESTIONNAIRE

### MEDICAL HISTORY

1. Name and phone number of Physician: \_\_\_\_\_
  2. When was your last physical exam? \_\_\_\_\_
  3. Do you have any health problems \_\_\_\_\_ YES NO
  4. Have you been hospitalized or had a serious illness/operation in the past five years? \_\_\_\_\_ YES NO
- If yes, please explain, \_\_\_\_\_

5. Do you have, or have you had any of the following diseases or problems? \_\_\_\_\_ YES NO
  - Rheumatic fever or rheumatic heart disease \_\_\_\_\_ YES NO
  - Congenital heart lesions, heart murmur or mitral valve prolapse \_\_\_\_\_ YES NO
  - Cardiovascular disease (heart attack stroke, angina or arteriosclerosis) \_\_\_\_\_ YES NO
  - High/low blood pressure \_\_\_\_\_ YES NO
  - Hepatitis A, B or C, jaundice or liver disease \_\_\_\_\_ YES NO
  - Seasonal allergies, Asthma or hay fever \_\_\_\_\_ YES NO
  - Fainting spells or seizures \_\_\_\_\_ YES NO
  - Diabetes \_\_\_\_\_ YES NO
  - Arthritis \_\_\_\_\_ YES NO
  - Tuberculosis \_\_\_\_\_ YES NO
  - Persistent cough or cough up blood \_\_\_\_\_ YES NO
  - Venereal disease \_\_\_\_\_ YES NO
  - Hip or Joint replacement \_\_\_\_\_ YES NO
  - Other \_\_\_\_\_ YES NO
  - Do you need to pre-medicate with an antibiotic before dental appointments? \_\_\_\_\_ YES NO  
Which antibiotic? \_\_\_\_\_
  - Abnormal bleeding with extractions, surgery, other \_\_\_\_\_ YES NO
  - Blood disorders, such as anemia \_\_\_\_\_ YES NO
  - History of surgery or radiation therapy for a tumor, growth in the head or neck \_\_\_\_\_ YES NO
6. Are you taking any of the following drugs or medications?
  - Antibiotics or sulfa drugs \_\_\_\_\_ YES NO
  - Medication for high blood pressure \_\_\_\_\_ YES NO
  - Anticoagulants (blood thinners) \_\_\_\_\_ YES NO
  - Cortisone (steroids) \_\_\_\_\_ YES NO

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- Tranquilizers \_\_\_\_\_ YES NO
  - Aspirin \_\_\_\_\_ YES NO
  - Insulin or similar drugs \_\_\_\_\_ YES NO
  - Digitalis, Nitroglycerine or drugs for heart trouble \_\_\_\_\_ YES NO
  - Hormone therapy \_\_\_\_\_ YES NO
  - Supplements or vitamins \_\_\_\_\_ YES NO
7. Do you use tobacco products? \_\_\_\_\_ YES NO  
If so, what kind and how often? \_\_\_\_\_
8. Are you HIV positive? \_\_\_\_\_ YES NO
9. Are you allergic or have reacted adversely to:
- Local anesthetics
  - Penicillin or other antibiotics
  - Sulfa drugs
  - Barbiturates, sedatives
  - Aspirin
  - Ibuprofen
  - Iodine
  - Latex
  - Other
10. Do you have any disease, condition or problem not listed above that we need to know? \_\_\_\_\_ YES NO  
If so, please explain \_\_\_\_\_  
\_\_\_\_\_

## Women Only

11. Are you pregnant? \_\_\_\_\_ YES NO
12. Are you taking Oral Contraceptives? \_\_\_\_\_ YES NO

## DENTAL HISTORY

- How long have you been to the dentist?
- What was done then?
- Did you have x-rays?
- Have you lost any teeth? \_\_\_\_\_ Why? \_\_\_\_\_
- Are your teeth sensitive to: Cold Heat Sweets Sour
- How often do you brush your teeth? \_\_\_\_\_ Type of tooth brush \_\_\_\_\_
- Do you use dental floss \_\_\_\_\_ How often? \_\_\_\_\_
- Do you have bleeding gums? \_\_\_\_\_ When? \_\_\_\_\_
- Do you use mouth wash? \_\_\_\_\_ Name: \_\_\_\_\_
- Do you experience pain when brushing or flossing your teeth? \_\_\_\_\_
- Do you grind or clench your teeth? \_\_\_\_\_ When? \_\_\_\_\_
- Have you had gum treatment? \_\_\_\_\_ When and type? \_\_\_\_\_
- Do you hear popping, clicking or noises when you chew? \_\_\_\_\_
- Are you aware of any swelling or lump in your mouth? \_\_\_\_\_
- Have you had any serious trouble associated with previous dental treatment? \_\_\_\_\_

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If so, explain \_\_\_\_\_

Please describe any current medical treatment, impending operation, or any other medical or dental information that may possible affect your dental treatment: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Patient \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_

**AUTHORIZATION TO DISCUSS TREATMENT**

I, \_\_\_\_\_, give Occoquan Family and Cosmetic Dentistry permission to discuss my case and/or treatment with:

NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_

NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_

NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Relationship to Patient (if minor): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Patient, Parent, Guardian, or Representative

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

I understand that, under the health Insurance 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 various health care providers who may be involved in your treatment directly and indirectly.

. Obtain payment from third-party payers.

. We may use or disclose health information to provide appointment reminders (voice mail, letters, postcards), or in connection with our health care operations including quality assessments, improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioners performance, certification, licensing or credentials.

. We may use or disclose health information to notify or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. We will use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

. We may use or disclose your health information when we are required to do so by law.

. We may disclose your health information to appropriate authorities to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others, if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

I have received, read and understand your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this Office has the right to change its notice of privacy practices from time to time and that I may contact this Office 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.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using our contact information.

Patient Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_