TruSMILES DENTISTRY

Patient Registration Form

Patient Last Name: _____ **First** _____ **Initial:** _____

How do you wish to be addressed? _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ City _____ State _____ Zip _____

Telephone (Home): _____ Work: _____ Mobile: _____

Email: _____ Social Security Number: _____

Primary Insurance:	**Secondary Insurance:**
Subscriber Name: _____	Subscriber Name: _____
Subscriber ID: _____	Subscriber ID: _____
Date of Birth: _____	Date of Birth: _____
Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone: _____
Insurance Company: _____	Insurance Company: _____
Insurance Group: _____	Insurance Group: _____
Insurance Phone:	Insurance Phone:

Responsible Party (If Minor)

Patient Last Name: _____ **First** _____ **Initial:** _____

How do you wish to be addressed? _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ City _____ State _____ Zip _____

Telephone (Home): _____ Work: _____ Mobile: _____

Email: _____ Social Security Number: _____

Emergency Contact:

Last Name: _____ First: _____ Initial: _____

Telephone (☐ Mobile ☐Work ☐Home) _____

Consent:

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of the information concerning my (or my child's) health care, advise, and treatment, to another dentist, or for evaluating any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the dentist and understand that my insurance benefits may pay less than the actual bill for service and that I am responsible for any services not paid or covered by my insurance benefits and any account balances.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

(Responsible party if under 18)

TruSMILES DENTISTRY

DENTAL & MEDICAL HEALTH

PLEASE COMPLETE ALL INFORMATION - THANK YOU

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No
Bad breath	☐	☐	Head, neck, jaw pain, or aches	☐	☐
Blisters on lips or mouth	☐	☐	Lip or cheek biting	☐	☐
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings.	☐	☐
Chew on one side of mouth.	☐	☐	Mouth breathing	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Orthodontic treatment	☐	☐
Smokeless tobacco	☐	☐	Nitrous Oxide	☐	☐
Dry mouth	☐	☐	Periodontal treatment	☐	☐
Food collection between teeth.	☐	☐	Sensitivity to pressure or cold/sweet	☐	☐
Growths or sore spots in your mouth	☐	☐	Clench or Grind.	☐	☐
Gums swollen, tender or bleeding.	☐	☐			

How often do you floss? _____ How often do you brush? _____

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? ☐Yes ☐No

If Yes, please explain _____

Have you ever had trouble from previous dental care? ☐ Yes ☐NO

Please Explain? _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____

Have you had any serious illnesses or operations Yes☐ No ☐ If yes, please describe _____

Have you ever had a blood transfusion? Yes ☐ No ☐ If yes, give approximate dates _____

(Women) Are you pregnant? Yes ☐ NO ☐ Due date _____ Nursing? Yes ☐ No☐ Taking birth control pills? Yes ☐ No ☐

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	☐	☐	Headaches	☐	☐	Slow healing wounds	☐	☐
Anemia	☐	☐	Heart murmur	☐	☐	Stroke	☐	☐
Arthritis, Rheumatism	☐	☐	Heart problems	☐	☐	Swelling of feet or ankles	☐	☐
Artificial heart valves	☐	☐	Hepatitis type	☐	☐	Thyroid problems	☐	☐
Artificial joints	☐	☐	Herpes.	☐	☐	Tonsilitis	☐	☐
Asthma	☐	☐	High blood pressure	☐	☐	Tuberculosis	☐	☐
Required Hospitalization	☐	☐	Any immune deficiency	☐	☐	Tumor or growth on head/neck	☐	☐
Have you used steroids	☐	☐	Jaundice	☐	☐	Ulcer	☐	☐
Date of last episode	☐	☐	Kidney disease	☐	☐	Venereal disease.	☐	☐
Bleeding abnormally with operations or surgery	☐	☐	Low blood pressure	☐	☐	Weight loss, unexplained	☐	☐
Blood disease, clotting disorders	☐	☐	Mitral valve prolapse	☐	☐	Do you wear contact lenses?	☐	☐
Cancer	☐	☐	Osteoporosis	☐	☐	Do you consume alcoholic beverages	☐	☐
Chemical dependency	☐	☐	Osteopenia	☐	☐	Are you currently under the care of a Physician?	☐	☐
Chemotherapy	☐	☐	Pacemaker	☐	☐	Are you allergic/sensitive to Latex?	☐	☐
Circulatory problems	☐	☐	Radiation treatments	☐	☐	Allergic to Penicillin, Aspirin, or other drugs?	☐	☐
Cortisone treatments.	☐	☐	Respiratory disease	☐	☐	*If Yes, please specify*		
Cough, persistent or bloody	☐	☐	Rheumatic fever	☐	☐			
Diabetes	☐	☐	Scarlet fever	☐	☐			
Emphysema	☐	☐	Shortness of breath	☐	☐	List any medications that you are taking:		
Epilepsy	☐	☐	Sinus trouble	☐	☐			
Fainting	☐	☐	Sickle cell anemia	☐	☐			
Glaucoma	☐	☐	Skin rash	☐	☐			

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Reviewed by: _____ Date _____

TruSMILES DENTISTRY

HIPAA Authorization

HIPAA Authorization for Uses and Disclosures of Protected Health Information

Authorization of Uses and Disclosures.
I hereby authorize and direct Tru Smiles Dentistry as well as their associated dentists, providers, employees, office staff, and agents including affiliated health care practitioners to use and disclose my protected health information ("Information"), as described below

Description of Information.
I understand that my Information includes, but is not limited to my name, date of birth, and other personal information and identifiers (including my address), medical and dental information. including information about my health condition and related medical conditions, medical and dental records. and financial information (including information about my insurance) as well as other personal information collected by Tru Smiles Dentistry about me or other provided by me to Tru Smiles Dentistry.

Purposes.
I authorize and direct Tru Smiles Dentistry to use my Information, and to disclose my Information for the following purposes:

a. **For marketing communications.** For example – Tru Smiles Dentistry may contact me about new products. services, or events that it thinks may be of interest to me. Tru Smiles Dentistry may also contact me for the purposes of fundraising, publicity and advertising for broadcast in print or other media including on the internet. Note that Tru Smiles Dentistry may receive remuneration, either directly or indirectly, in exchange for making these marketing communications.

b. **For purposes related to treatment, payment (e.g., to a parent, other family member or personal representative who may assist in coordination of my care) and/or Tru Smiles Dentistry health care operations, with the following individuals:**

Name:_____

Relationship:_____

Telephone Number: _____

Treatment not Conditioned; Signing is Voluntary.
I understand that Tru Smiles Dentistry will not condition my treatment on signing this Authorization I can choose not to sign this Authorization and will still be able to receive treatment. In addition, if I refuse to sign this Authorization Tru Smiles Dentistry is still permitted to make uses and disclosures of my Information for treatment (e.g., to other health care providers), payment (e.g., to my insurance company). and health care operations (e.g., for internal audits), as permitted by law.

Expiration.
Unless revoked. this Authorization will expire ten (10) years from the date signed below.

Revocation.
I understand that I have the right to revoke this Authorization by providing written notice of my desire to revoke to **Tani Rainford DMD, 3425 Buford Dr, Buford Ga, 30519**, However, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this Authorization.

Potential for Redisclosure.
I understand that Information disclosed pursuant to this Authorization may be redisclosed by Tru Smiles Dentistry and may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA"). a federal privacy law.

Copy.
I understand that I will be provided with a copy of this signed Authorization.

I hereby certify that I am over the age of 18 and I have read the foregoing and fully understand the contents.

Name *(please print)*
Patient Signature:_____ Date:_____

Date of Birth _____ Age:

Parent! / Guardian / Personal Representative Signature (required if subject is under 18 years of age)

Description of Relationship to Patient: _____

For Office Use Only
We attempted to obtain a written authorization for the use and disclosure of protected health information, but authorization was refused.

Signature: _____ Date: _____

Financial Policy

Tru Smiles Dentistry is committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fee, financial policy, your responsibility.

- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR ALL PATIENTS**
- **WE ACCEPT CASH, AMERICAN EXPRESS, VISA, MASTERCARD, DISCOVER AND CARE CREDIT.**
- **TRU SMILES DENTISTRY PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF A PARTICULAR DENTAL SERVICE IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

INSURANCE

TRU SMILES DENTISTRY PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PORTION OF PARTICULAR DENTAL SERVICE (S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE. THIS AMOUNT MAY BE SUBJECT TO ADJUSTMENT WHEN THE DENTAL SERVICE(S) ARE ADJUDICATED BY THE INSURANCE COMPANY. IN ADDITION, CERTAIN INSURANCE COMPANYS HAVE ANNUAL LIMITATIONS FOR THE AMOUNT OF DENTAL SERVICES THAT CAN BE REIMBURSED WITHIN EACH YEAR. IF YOU OR YOUR FAMILY EXCEEDS THESE ANNUAL LIMITIAIONS IN ANY PLAN YEAR, YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF DENTAL SERVICES THAT EXCEEEDED THE PATICULAR PLAN'S LIMITATIONS. THE PATIENT IS REPONSIBLE FOR MONITORING THE AMOUNT OF HIS/HER REMAINING BENEFITS FOR ANY ANNUAL BENEFIT PERIOD. THE PATIENT MAY NOT RELY UPON ANY INFORMATION PROVIDED BY TRU SMILES STAFF REGARDING HIS/HER REMAINING BENEFIT IN ANY SUCH BENEFIT PERIOD.

The claims we submit to insurance companies indicate that you have assigned those benefits to Tru Smiles Dentistry. However, it you are paid by the insurance company instead of Tru Smiles Dentistry you them become responsible for the total account balance and payment would be expected immediately.

WE WILL RESEARCH YOUR BENEFITS AND GIVE YOU THE BEST ESTIMATE OF WHAT IS TYPICALLY PAID BY YOUR INSURACNCE CARRIER. THE PAYMENT MAY BE MORE OR LESS THAN WE ESTIMATE. INSURANCE CARRIERS CHANGE, POLICIES LAPSE, AND NUMEROUS OTHER FACTORS BEYOND OUR CONTROL MAY ALTER THE ACTUAL PAYMENT.

YOU AS A PATIENT ARE ALWAYS RESPONSIBLE FOR ANY CHARGES THAT ARE NOT COVERED BY YOUR INSURANCE COMPANY.

DELINQUENT PAYMENTS

All payments returned due to non-sufficient funds will be subject to a NSF fee of $35.00. Accounts that are delinquent more than 60 days from the date of billing are subject to a 1.5% (18 % annually) finance charge. If your account is sent to our collections agency you will be responsible for collection and court cost along with attorney's fees.

Cancellation/ No Show/ Appointment Confirmation Policy:

We do require a 48-hour notice for all cancellations. Unless cancelled at least 48 hours in advance our policy is to charge for missed appointments at the rate of $50 per 30 min of missed appointment time. Please help us serve you better by keeping scheduled appointments, or by contacting the office 48-hours prior to your scheduled appointment.

We do require you confirm your appointment via text, email or phone.

Thank you for understanding our Financial Policy. Please let us know if you have any questions our concerns.

Responsible Party Signature _____ Date _____

Communication Policy

Email appointment confirmations
By opting in to email appointment confirmations, you will receive reminders of upcoming appointments and reminders of schedule appointments.

Text appointment confirmation
By opting in to text appointment confirmations, you are authorizing Tru Smiles Dentistry to send text message appointment reminders to you on your provider cell phone number.

You agree that all individuals associated with your account may receive alerts referencing the account guarantor and/or dependents. Text message charges from your cell phone provider may apply.

Your enrollment indicates that you are at least 18 years of age and agree to all terms and conditions of the use for text messaging service. By opting in to our text message system you are providing consent to receive personal information such as appointment confirmation, account balance information, and other communication information deemed appropriate.

Patient privacy is of utmost importance to us. Our communication routes via email and text are fully HIPAA compliant. The contact information you share with us is only used for communication purposes. We do not share your contact information, or personal data with any unauthorized individuals or entities.

Patient Signature: _____ Date: _____
(By signing above I agree to receive electronic communication via text and/or email)

TruSMILES DENTISTRY

Media Rights Photography and/or Social Media Consent and Release Form

For News Media, Social Media, Promotional Materials, Written Articles, Research and/or Photographs I (patient) _____ hereby authorize providers at Tru Smiles Dentistry to take photographs, and/or videos of me, my face, jaws and teeth, before, during and after treatment. Such photographs, and/or videos may include photographs and/or videos of me, and my entire face/mouth.

I consent to allow the photographs or videos to be used for the following purposes:

Dental records, dental research, dental education including lectures, seminars, demonstrations, professional publications such as journals or books.

Social media (including without limitation, Facebook, Instagram, Twitter, Google, Yelp) marketing material including websites and printed materials, for the purposes of patient education.

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential to the extent practicable (other than if full face photographs are used).

- I hereby grant to providers at Tru Smiles Dentistry and any of its assigns and licensees all rights to exhibit this work in print and electronic form, publicly or privately, and to distribute, market and/or sell copies.
- I waive any and all rights, claims, or interests I may have to control the use of my identity or likeness in whatever media used.
- There is no time limit on the validity of this release, nor is there any geographic limitation on where these materials may be distributed.

- I do not expect compensation, financial or otherwise, for the use of these photographs and/or videos.

☐ I ACCEPT CONSENT OF PHOTOGRAPHY

☐ I DECLINE CONSENT OF PHOTOGRAPHY

Patient Signature: _____ **Date** _____

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health. Information. We must follow the privacy practices that are described in this notice while it ii in effect. This notice take effect 2/ 20 /2023 and will remain in effect until we replace it.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

- **Treatment Services:** We may use or disclose your health information to all of our staff members, other dentists, your physicians, and/or other health care providers taking care of you.
- **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.
- **Health Care Operations**: we may use and disclose your information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
- **Legal Requirements:** We may use or disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activates. Health information for inmates in custody of law enforcement may be provided to correctional institutes.
- **Individuals Involved in you care or payment of your care**: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.
- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Research:** We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.
- **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).
- **Disaster Relief:** We may use or disclose your health information to assist in disaster relief efforts.
- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an

inmate or patient.

- **Secretary of HHS:** We will disclose your health information to the secretary of the U.S Department of Health Human Services when required to investigate or determine compliance with HIPPA.

- **Research:** We may use or disclose medical information to researchers when an institution's review board or special

- **Enforcement:** We may disclose your PHI for law enforcement purposes as permitted by HIPPA, as required by law, or in response to a subpoena or court order.

- **Health Oversight Activities**: We may disclose your information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil right laws.

- **Coroners, Medical Examiners, and Funeral Director**s: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

- **Fundraising:** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communication.

- **Other Authorizations:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. Your authorization is required, with few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. If you give us authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

PATIENT RIGHTS

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request information we maintain on paper, we may provide photocopies. If you request information we maintain electronically, you have the right to an electronic copy. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

- **Accounting of Disclosures:** With the exception of certain disclosures you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for the additional requests.

- **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request may include (1) what information you want to limit, (2) whether you want to limit or use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for the purpose of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid or practice in full.

- **Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We will accommodate all reasonable request. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

- **Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and must explain the reason for the amendment.) We may deny your request under certain circumstances.

- **Breach Notification:** We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure as required by law.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Privacy Official: Dr Tani Rainford Email:
info@trusmilesga.com
Address: 3425 Buford Dr. Suite 300, Buford GA. 30519

TruSMILES DENTISTRY

HIPAA Privacy Practices Acknowledgment

Section A: Patient Information

Patient Name: _____

Section B: Acknowledgment of Receipt of HIPPA Notice of Privacy Practices

Use of Privacy Practices: Our Notice provides a description of our treatment, payment activities, and healthcare 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 Notice accompanies this Acknowledgement. We encourage you to read our Notice carefully and completely before signing this Acknowledgment.

Section C: Signature

I, _____ have had full opportunity to read and consider the contents of this Acknowledgment and the Notice of Privacy Practices. I understand that. by signing this Acknowledgment. I am giving my authorization to your use and disclosure of my protected health information in accordance with the Notice.

Signature: _____ Date: _____

If this Acknowledgment is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

Section D: For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other *(please specify)*: _____

Signature: _____ Date: _____

You are entitled to a copy of this acknowledgment after you sign it.

TruSMILES DENTISTRY

COVID-19 Questionnaire

Acknowledgement

The 2019 novel coronavirus (COVID-19} is a highly contagious disease with a long incubation period. This makes it very difficult to determine who may be infected. Despite all of the precautions Tru Smiles Dentistry has taken to ensure patient safety, the characteristics of COVID-19 and that of certain aerosol-generating procedures means that there is a risk of contracting COVID-19 through dental treatment. I understand and accept the risk related to COVID-19 from seeking dental treatment for myself or for my minor child. I also acknowledge that I (or my minor child) could contract COVID-19 from outside the dental office and unrelated to my visit today

Patient Name: _____

Appointment Date: _____

Please answer the following questions.

1. In the past 10 days, have you been diagnosed w/ a laboratory-confirmed case of COVID-19 or are you currently awaiting COVID-19 test results?

   YES/ NO

2. Are you currently experiencing, or have you experienced in the last 10 days, a fever of 100.4 or higher and/or other flu-like symptoms?

   YES/ NO

3. In the past 10 days, have you been in close physical contact with (6 ft. or closer) or cared for a person with a laboratory-confirmed case of COVID-19?

   YES/ NO

4. In the past 10 days, have you traveled internationally?

   YES/ NO

Patient/Guardian Signature: _____

Clinical Signature: _____