Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control 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 other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____ YES	_____ NO
DO YOU HAVE A FEVER?	_____ YES	_____ NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____ YES	_____ NO
DO YOU HAVE A DRY COUGH?	_____ YES	_____ NO
DO YOU HAVE A RUNNY NOSE?	_____ YES	_____ NO
DO YOU HAVE A SORE THROAT?	_____ YES	_____ NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____ YES	_____ NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____ YES	_____ NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?	_____ YES	_____ NO

IF SO, WHERE? _____

RENO ORAL AND MAXILLOFACIAL SURGERY

Please Print Clearly

PATIENT INFORMATION

Date_____

Legal Name (First)_____Middle Initial_____Last_____

Preferred Name_____Employer Name/Student Status_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Email_____

Date of Birth_____ Age_____Sex ☐ M ☐ F SSN_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed or ☐ Minor

Referring Dentist/Doctor_____ General Dentist_____
(Circle one)

Spouse's Name_____ Date of Birth_____

☐ **Use address for Guarantor/Financially Responsible Party**

Information must be filled out completely if you wish us to bill insurance*

PRIMARY DENTAL INSURANCE

Insurance Company_____ ☐ **DENTAL** ☐ **MEDICAL**

Policy Holder's Name_____Relationship to Patient_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Email Address_____

Policy Holder's SSN_____ID #_____ Date of Birth_____

Group #_____Employer Name_____Occupation_____

☐ I authorize the dentist and/or his staff to discuss my surgical care with the above named contact _____(Initial)

SECONDARY INSURANCE

Insurance Company_____ ☐ **DENTAL** ☐ **MEDICAL**

Policy Holder's Name_____Relationship to Patient_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Email Address_____

Policy Holder's SSN_____ID #_____ Date of Birth_____

Group #_____Employer Name_____Occupation_____

Is patient covered by additional insurance? ☐ **Yes** ☐ **No**

☐ I authorize the dentist and/or his staff to discuss my surgical care with the above named contact _____(Initial)

If you have insurance: We will bill your insurance as a courtesy to you. Payment is still your responsibility. If insurance(s) does not pay within 45 days, you will be billed for the balance owed. _____(Initial)
Cash/Check or Credit: If you do not have insurance coverage, payment is due in full at time of service unless other financial arrangements have been made in advance. _____ (Initial)

Daniel F. Muff, D.D.S., M.D.
Kimberly C. Bentjen, D.D.S., M.D.

HEALTH HISTORY

Oral and Maxillofacial Surgery

Patient's Name _____ **Date** _____

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations, or hospitalizations? If so, please list: ..... Y N
   _____
   _____
   _____
   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
   - S. HIV, AIDS or ARC? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Intravenous Bisphophonates (Aredia, Zometa)? ..... Y N
   - I. Digitalis, Nitroglycerin or other heart medications? Y N
   - J. Any regular prescription medicine, pills or drugs .. Y N
     If Yes, please list: _____
     _____
     _____
     _____
     _____
     _____
     _____
   - K. Herbal or Holistic remedies, Vitamins or over-the-counter medications? ..... Y N
     If Yes, please list: _____
     _____
     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other painkillers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N
     _____
     _____
10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Do you drink alcohol? ..... Y N
    How much per day? _____
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FEMALES ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ..... Y N
    - B. Are you nursing ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Name of Physician: _____ **Phone:** _____

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

_____ _____ _____

Date **Signature of Person Completing Health History** **Doctor's Initial**

EMERGENCY CONTACT

(Specify someone other than the account guarantor or insured party)

Name_____ Relationship_____

Home/Cell Phone_____ Email Address_____

☐ I authorize the dentist and/or his staff to discuss my surgical care with the above named contact _____(Initial)

I, _____certify that I, and/or my dependent(s), have insurance with_____and assign directly to Dr. Daniel F. Muff 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 they are paid by insurance. I authorize the use of my signature on all insurance submissions. _____**Initial**

Dr. Daniel F. Muff & Dr. Kimberly C. Bentjen may use my healthcare information and may disclose such information to my insurance and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I am aware that Dr. Daniel F. Muff & Dr. Kimberly C. Bentjen are HIPPA compliant and if I desire to have a printed copy of the Notice of Health Insurance Portability and Accountability Act (HIPPA), I must request a copy. _____ **Initial**

· Patients who carry dental insurance must understand that all oral surgery services furnished are charged directly to the patient and that he or she, not the insurance company, is personally responsible for payment of all oral surgery services rendered. Your insurance policy is a pre-determined arrangement between you/your employer and the insurance company. We are not a party to that contract. This office will help prepare and submit the insurance forms for our patients, assist in making collections from insurance companies, and to credit any such collections received to the patient's account. Any co-pay quoted from this office is an estimate only, not a guarantee of coverage/payment. Unfortunately, insurance benefits will almost always be less than anticipated. It is **your responsibility** to contact your insurance to determine your particular benefits or requirements. **This office cannot render services on the assumption that our charges will be paid in full by an insurance company. _____Initial**

· I understand that Dr. Daniel Muff & Dr. Kimberly C. Bentjen are **not contracted providers** with any *Medical* Insurance including Medicare. _____**Initial**

· After insurance payment is applied, I understand that should the balance be $5.00 or under, I will not be billed, or should the overpayment be $5.00 or under, I will not be refunded. _____**Initial**

· I grant my permission to this office to telephone me at home or at my workplace to discuss matters related to this form or my treatment. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my surgical care. _____**Initial**

· I understand that it is my responsibility to notify Dr. Daniel F. Muff, Dr. Kimberly C. Bentjen and staff of any medical and/or insurance changes. To the best of my knowledge, all of the information provided is correct and true. _____**Initial**

_____

(Signature of Patient/Guardian/Account Guarantor) (Date) (Relationship to Patient)

Informed Consent for Controlled Substance Therapy for Pain

Daniel Muff, DDS, MD Dr. Kimberly Bentjen, DDS, MD
Oral and Maxillofacial Surgery

In Nevada, per Assembly Bill 474, we as prescribers must inform our patients of information regarding the treatment of pain with the use of a controlled substance. It is important that you review the following information carefully and request additional information you may need to make an informed choice about the medication(s) prescribed. Please review the information listed here and initial each item.

_____ I understand that I am being prescribed medications, including controlled substances, for the treatment of pain.

_____ I understand that all pain medications, including controlled substances, have different benefits and risks in the treatment of my symptoms. I have been advised of the potential risks and benefits of treatment using controlled substances.

_____ I understand that prescription-controlled substances can carry serious risks of addiction and overdose, especially with prolonged use.

_____ I understand that I am not to use the controlled substance prescribed to me in conjunction with other recreational drugs, alcohol, or other prescribed medications (unless directed by my prescriber).

_____ I understand that non-opioid alternative means of treatment are useful for my symptoms, which include acetaminophen (Tylenol) and non-steroidal anti-inflammatory drugs such as Ibuprofen (Advil and Motrin) and naproxen (Naprosyn).

_____ I understand that when I take a controlled substance, I may experience certain reactions or side effects that could be dangerous, including, but not limited to, sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, altered judgement, slowing of my reactions, and a decrease in the drive to breathe.

____ I understand that when I take a controlled substance, it may not be safe for me to drive a car, operate machinery, or take responsibility for the care of other people. I understand that when under the effects of these medications, accidents may occur that may result in injury to myself and others.

_____ I understand that exposure to controlled substances may cause physical dependence on them, meaning that not taking the medications regularly may result in withdrawal sickness. Withdrawal symptoms feel like those associated with the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

_____ I understand that I may become addicted to controlled substances and may require addiction treatment. I have discussed with my prescriber the proper use of the controlled substance prescribed.

_____ I understand that anyone can develop an addiction to pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past or who have a parent or sibling who has had drug or alcohol abuse problems are at higher risk. I have told my prescriber if I or anyone in my family has had any of these types of problems.

_____ I understand that I must store prescriptions in a secure place, not accessible to children, other family members, and others who might use the medications inappropriately. I understand that to safely dispose of unused medications, I can return the unused medications in the bottle to a local pharmacy, a local drug-take back day, or a local police or sheriff substation in my community, or I may safely dispose of them by dissolving them in a Dettera pouch. I understand that I am not to dispose of unused medications into the toilet or sink.

_____ I understand that my doctor is not permitted to refill my medication via telephone and, therefore, any requests for refills may require a consultation appointment. I understand that my doctor may decline to refill my prescription if not medically necessary or if harmful to my well-being. I understand that I am being prescribed a controlled substance for a short duration and that prescriptions for additional periods of time may require additional consultation, reassessment, and agreements.

_____ I understand that due to the risk of possible overdose resulting from of controlled substances, the opioid overdose antidote naloxone (Narcan®) is now available without a prescription. I may obtain naloxone (Narcan®) from a pharmacist.

_____ For **Women:** It is my responsibility to tell my prescriber immediately if I think I am pregnant or if I am thinking about getting pregnant. I understand the risk to a developing fetus from chronic exposure to controlled substances during pregnancy include the risks of fetal dependency on the controlled substance, neonatal abstinence syndrome, neurologic and heart problems, prematurity, and fetal or neonatal death.

Informed Consent:
I understand each of the statements above. By signing, I give my consent for treatment of my pain condition with medications, including controlled substances. I have had the opportunity to ask any questions regarding my treatment of pain with medications, including controlled substances, and I am satisfied that my questions have been adequately answered.

_____	_____	_____
Patient Name printed	Patient Signature	Date

Unemancipated Minor:
As the Parent/Guardian, I have discussed with the prescriber the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion.

_____	_____	_____
Parent/Guardian Name printed	Parent/Guardian Signature	Date