General Informed Consent

Patient Name_____

We are delighted you have selected us to provide dental care for you, and you are in great hands!

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to others dentist's or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations, X-rays, Preventative Services, Crowns, Bridges, Restorations, Dentures, Extractions, Implants, Whitening, Bone grafting, ect.

DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examinations, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient/Guardian Signature_____ Date_____

Witness Signature_____

Doctor's Signature_____

Welcome to Calm Spring Dental

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help!

Patient Information (CONFIDENTIAL)

Date_____

NAME_____Birthdate_____Home Phone_____

Address_____City_____ State/Zip_____

Email (optional)_____ Cell Phone_____Soc. Sec. #_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer_____Work Phone_____

Business Address_____ City_____State/Zip_____

Spouse or Parent/Guardian's Name_____Work Phone_____

Spouse or Parent/Guardian's Employer_____City_____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency (living in same home) _____ Phone_____

Person to Contact in Case of Emergency (not living in same home) _____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____Relation to Patient_____

Address_____Home Phone_____

Email (optional)_____Cell Phone_____

Driver's License #_____ Birthdate_____SSN_____

Employer_____Work Phone_____

Is this person currently a patient in our office? ☐ Yes ☐ No Are there other family members? ☐ Yes ☐ No

Insurance Information

Name of Insured_____Relation to Patient_____

Birthdate_____SSN_____Date Employed_____

Name of Employer_____Work Phone_____

Address of Employer_____City_____State/Zip_____

Insurance Company_____ Group #_____Policy ID #_____

Insurance Co._____Address_____City State/Zip_____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured_____Relation to patient_____

Birthdate_____ SSN_____ Date Employed_____

Name of Employer_____ Work Phone_____

Address of Employer_____ City_____ State/Zip_____

Insurance Company_____Group #_____ Policy ID #_____

Dental History

NAME: _____ DATE:_____

Please check any of the following problems that apply to you.

___Sensitivity (hot, cold, sweet)
___Tooth pain or discomfort when chewing
___Headaches, earaches, neck pain
___Jaw joint pain
___Teeth or fillings breaking
___Grinding or clenching teeth
___Bleeding, swollen or irritated gums
___Loose, tipped or shifting teeth
___Bad breath or bad taste in your mouth

Do you have or have you had any of the following:

___Dentures colored fillings
___Periodontal (gum) treatments
___Partial denture
___Braces

Please share the following dates:

___Your last cleaning ____/____
___Your last oral cancer screening ____/____
___Your last complete X-rays ____/____

Name of Previous Dentist:
_____

City: _____ State:_____

Phone Number: (___)_____

General Anesthesia Questions: (required)

Height: _____ Weight: _____

Have you ever had any unusual reactions or complications to medications or anesthesia?
NO DS Yes NO DS No **Is yes, please explain below:**
_____
_____
_____

Are you interested in whiter teeth?

___Yes ___No ___ I would like more information.

Do you smoke or use chewing tobacco?

___Yes How Much _____
How Long _____
___No

If you could change your smile, you would:

___Make it brighter
___Make it straighter
___Close spaces
___Replace black metal fillings with tooth
___Repair chipped teeth
___Replace missing teeth
___Replace old crowns that don't match
___Have a smile makeover

One a scale of 1-10 with 10 the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____
_____

What is the most important thing to you about your dental visit?

_____
_____

EMERGENCY CONTACT **NOT** RESIDING WITH YOU:

Name: _____

Relationship: _____

Phone Number:
(____)_____

Created May 2021

CALM SPRING DENTAL

Patient's Medical History

Patient's Name: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No.	☐ N/A	_____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	☐ N/A	_____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	☐ N/A	_____
Are you taking any medications, pills, or prescription drugs?	☐ Yes	☐ No	☐ N/A	_____
Do you take or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	☐ N/A	_____
Are you on a special diet?	☐ Yes	☐ No	☐ N/A	_____
Do you use tobacco?	☐ Yes	☐ No	☐ N/A	_____

Women: Are you ☐ Pregnant or Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Local Anesthetics ☐ Other (Please specify) _____

Do you have, or have ever had, any of the following?

☐ AIDS/HIV Positive.	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine.	☐ Heart Attack/Failure.	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*.	☐ Lung Disease	☐ Stomach & Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding.	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problems.	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness.	☐ High Blood Pressure.	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

***Conditions may require medication.** **N/A – Not answered by patient**

Have you ever had any serious illness not listed above? Yes No N/A. If yes, please specify_____

Comments:_____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize to have photographs of my face, jaws and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature of Patient, Parent or Guardian_____Date_____

Created May 2021

Calm Spring Dental

HIPPA 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.

The Dental Practice Covered By This Notice

This notice describes the privacy practices of Calm Spring Dental Office ("Dental Practice").
"We" and "our" means the Dental Practice. "You" and "your" means our patient.

How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this notice, you can either write or call the Privacy Official for our Dental Practice.

Dental Practice Name:	Calm Spring Dental
Privacy Official for Dental Practice:	Dr. Obinna Ejike
Dental Practice Email Address:	calmspring@calmspringdental.com
Dental Practice Mailing address:	11034 Military Dr. West Suite 104 San Antonio, TX 78251
Dental Practice Phone Number:	(210) 864-0272

Information Covered By This Notice

This notice applies to health information about you that we create or receive and that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- Maintain the privacy of your health information:
- Give you this Notice of our legal duties and privacy practices with respect to that information: and
- Abide the terms of our Notice that is currently in effect.

Our Use and Disclosure of Your Health Information Without Your Written Authorization

Common Reasons for Our Use and Disclosure of Patient Health Information

Treatment. We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialist, physicians, or other health care professionals involved in your care.

Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including: review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing, audits, legal matters, and business planning and development.

Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, or email.

Treatment Alternative and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health related benefits and services that may be of interest to you.

Disclosure to Family Member and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information

The following uses and disclosures occur infrequently and may never apply to you. Disclosures Required by Law. We may use or disclose patient heath information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

Public Health Activities.

We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury, or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities.

We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions.

We may disclose patient health information in response to a (i) a court or administrative order or (ii) a subpoena, discovery request, or other unlawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes.

We may disclose patient health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors.

We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Organ, Eye and Tissue Donation.

We may use or disclose patient health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes.

We may disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety.

We may use or disclose patient health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Specialized Government Functions.

We may disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation.

We may disclose patient health information to comply with workers' compensations laws or similar programs that provide benefits for work related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

We will make other uses and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPPA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

Access.

You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

Amend.

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

Restriction Use and Disclosure.

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your request restrictions, with one exception. If you pay our of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

Confidential Communications: Alternative Means, Alternative Locations.

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

Accounting of Disclosures.

You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA) The first accounting we provide in any 12- month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

Receive a Paper Copy of this Notice.

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

We Have the Right to Change Our Privacy Practices and This Notice.

We reserve the right to change the terms of this Notice at any time. Any changes will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is in the top right-hand corner of the Notice.

To Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

Receipt of Privacy Practices – Acknowledgement

YOU MAY REFUSE TO SIGN THIS

By signing below, I am stating that I have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

An attempt to obtain written acknowledgement of Receipt of our Notice of Privacy Practices was attempted, however acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other

_____

_____

_____

Payment Policy

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the quality care needed to enjoy a healthy and confident smile.

PAYMENT IN FULL

Full payment is required at the time of service from all patients that do not have insurance coverage.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. We cannot guarantee any estimated coverage. Your unpaid deductible and any estimated portion of fees not covered by your insurance are due at the time of service. Because the insurance policy is an agreement between you and the insurance company, we ask that patients be directly responsible for all charges. If for any reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time.

PAYMENT OPTIONS

• CASH OR CHECK: For fees exceeding $300.00 per patient, we are happy to offer a 5% courtesy adjustment for all treatment paid at the time of service. This excludes Orthodontic care.
• CREDIT CARDS: For your convenience, we have made arrangements to accept payment by Master card, Visa, AmericanXpress
• PAYMENT PLANS: For patients who desire a monthly payment plan, we have made arrangements with a finance company. There are no application fees or down payment and the loan can be interest-free. Applications are available from our office and approval is provided quickly.

PAST DUE BALANCES

A past due balance is any amount owed from a prior visit where insurance is not pending or an insurance payment has not been received within 60 days. All unpaid balances are subject to a 1.5% monthly service charge. Any delinquent account will be required to pay all past due balances in full before incurring any new charges. All future charges will need to be paid at the time services are rendered. Severely delinquent accounts will be assigned to a collection agency.

RETURNED CHECKS

Checks returned for insufficient funds will be subject to a $30.00 service fee.

RED FLAG RULE

The Red Flag Rule was created by the Federal Trade Commission, along with other government agencies such as the National Credit Union Administration, to help prevent identity theft. The rule was passed in January 2008. In order to comply with this rule, our office will be requiring the following information in order to be treated in our facility.

1. All new patients will be required to present a valid photo identification card issued by a local, state or federal government agency, and we shall copy said identification to keep in our files: a. In the case where the new patient is a minor, photo identification of the patient's responsible party will be obtained; and b. In the case where a new patient does not have a valid photo ID, two forms of non-photo identification, one of which is issued by a state or federal agency, will be obtained as well as a water or utility bill or other form identifying the correct or current address.
2. For new patients with insurance, information will be verified with their insurance company prior to billing.
3. If Patient Refuses to Present Identification:
    a. In an emergent situation, we shall refer the patient to the nearest hospital for care;
    b. In a non-emergent situation we shall reschedule the appointment for a later date in which that patient will be required to bring the necessary identification. You have the right to a paper copy of this notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

Patient Signature: _____ Date:_____

CALM SPRING DENTAL COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK

_____ _____

Patient's Name Date of Birth

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.

I have read and understand the information stated above:

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature (optional) Date

Revised September, 2020

CALM SPRING DENTAL COVID-19 PANDEMIC PATIENT DISCLOSURES

_____ _____

Patient's Name Date of Birth

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19, also known as "Coronavirus," pandemic.

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 such disclosures may impact treatment decisions.

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. These symptoms may appear 2-14 days after exposure to the virus. It is important that you disclose any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Pre-Appointment		In-Office	
	Yes	No	Yes	No
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐	☐	☐
Have you tested positive for COVID-19?	☐	☐	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐	☐	☐
Have you traveled outside the United States or to high-risk areas in the past 14 days?	☐	☐	☐	☐
Do you have a fever or above normal temperature?	☐	☐	☐	☐
Have you taken any fever-reducing medications, including: ibuprofen (Advil, Motrin or other), acetaminophen (Tylenol or other), naproxen (Aleve or other) or aspirin in the last 14 days and, if yes, for what reason? _____	☐	☐	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐	☐	☐
Do you have a cough?	☐	☐	☐	☐
Do you have a runny nose?	☐	☐	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐	☐	☐
Do you have a sore throat?	☐	☐	☐	☐
Have you experienced chills or repeated shaking with chills?	☐	☐	☐	☐
Do you have muscle pain?	☐	☐	☐	☐
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐	☐	☐	☐
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐	☐	☐	☐
Do you otherwise feel unwell?	☐	☐	☐	☐

CALM SPRING DENTAL COVID-19 PANDEMIC PATIENT DISCLOSURES

_____ _____

Patient's Name Date of Birth

I fully understand and acknowledge the above information, risks and cautions and have disclosed to my provider any other conditions in my health history. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature (optional) Date

Revised September, 2020

CALM SPRING DENTAL PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name: _____
Last First MI Maiden or Other Name

Date of birth: _____/_____/_____ Phone Number: _____

Address: _____City: _____State: _____Zip:_____

I authorize Dr._____ and his practice permission to take and use photographs, slides, and or videos (hereafter referred to as images) of my and or my child's face, jaws, mouth, and teeth for the purpose of: Teaching (i.e. Educational materials) and advertising or marketing (i.e. Calm Spring Dental Web site, social media, brochures, etc.)

I understand that once the image(s) have been posted, the image(s) can be downloaded by any computer user. I will hold Calm Spring Dental, the doctors, the staff and its representatives harmless from any such use or download.

I understand that the image(s) may be cropped or altered, and that my or my child's name or other identifying information will be kept confidential.

I expect no compensation, financial or otherwise, for the use of the image(s).

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already used the image(s) prior to me canceling this authorization, which would not prohibit any release done prior to the date of cancelation.

To cancel this agreement, I must write a letter to the doctor or practice advising of my wish to cancel my authorization to release image(s) taken of me or my child by this practice. I (or my authorized representative) must sign and date the letter.

_____ _____
Patient Signature/Legal representative Date

_____
Relationship of legal representative