Cove Dental Care General Consent

Please read this form in its entirety before signing.

Medical History Information: Please understand that it is important that you divulge any information about your medical history to Dr. Getz. It is important that you inform us of any medicines that you are taking each time that you come to an appointment as some medication can cause harmful reaction with dental anesthetics, analgesics, antibiotics, or other medications. Please be sure to provide us with a list of any drug allergies you may have.

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. For example, a more extensive filling than originally diagnosed may be required due to additional decay, which may not be fully detectable on a radiograph, or needing root canal therapy following routine restorative procedures. I understand that sensitivity may occur after a newly placed filling. I give my permission to Dr. Getz to make any/all changes and additions as necessary after consultation.

Complications: Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness, and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion may be permanent), reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reaction, delayed healing, and treatment failure. The risks and complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced by the use of alcohol, tranquilizers, sedative or other drugs). It is not advisable to operate nay motor vehicle or hazardous device while experiencing side effects of the medications prescribed. Antibiotics are known to decrease effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.

X-Rays and Photos: Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide Dr. Getz with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. All patients 18 years and older will receive a full mouth series intra-oral x-rays. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We also take photos of your teeth as part of your permanent record. We will not release these photos to anyone without your permission.

Specific Problem Examinations: In the event that a patient requires only a specific problem be addressed (i.e. broken tooth, pain in one area, etc.), a problem focused evaluation will be done. X-rays will be taken in the specific area only, and a complete comprehensive examination will not be done. Dr. Getz cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency or urgent need. Any future treatment of other areas will require additional x-rays and a complete exam.

Minors: We MUST receive WRITTEN consent PRIOR to performing any non-emergency dental procedures on a minor. Grandparents, step-parents, friends, relatives, etc. are not legally allowed to consent to dental procedures, unless they have been given written consent by the parent or legal guardian. Please do not send your child to an appointment alone or with someone other than yourself, unless you have filled out any necessary consent forms prior to the appointment, otherwise we may have no choice but to reschedule your child's appointment to another day.

CANCELLATIONS: At Cove Dental Care, each appointment is customized for the patient and time is dedicated to you for the maximum quality of care achievable. We are 100% committed to you and ask that your commitment is received in return. **OUR OFFICE REQUIRES A 48 HOUR NOTICE UPON CANCELLING AN APPOINTMENT. If this agreement is not kept, you will be charged A LATE CANCELLATION FEE OF $75.00.** Initials________________ Date:_______________

Patient/Guardian Signature:____ Date:________________________

Cove Dental Care Email Consent

AUTHORIZATION TO UTILIZE UNENCRYPTED EMAIL MESSAGING TO COMMUNICATE PROTECTED HEALTH INFORMATION.

Electronic mail (email) messaging is a form of communication that may be utilized between you and Cove Dental Care. We use unencrypted email which is not secured communication. Encryption is the process of making information unreadable unless you have the password or key to decrypt the information.

I authorize Cove Dental Care to transmit patient information relating to my treatment, health, or payment by email or other electronic means without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Cove Dental Care's health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and/or payment records.

I understand that:

- Cove Dental Care does **NOT** email sensitive personal information such as social security numbers, credit card numbers, mental health diagnosis, etc.
- Risks with email are the acquisition by hackers or unintended recipients. If this happens, the information may be re-disclosed and no longer protected by privacy law.
- If I do not sign this form, information I request will be sent via U.S. Mail or be required to be picked up in person.
- My treatment, payment, enrollment, and eligibility will not be affected by my decision to sign this form.
- I am not obligated to sign this form.

If I elect to communicate from my workplace computer, I understand that my employer and its agents may have access to email communications between myself and Cove Dental Care. Email communication may become a part of my patient medical record and accessible to your clinical support staff as needed for your office operations.

EMAIL COMMUNICATION SHOULD NEVER BE USED IN THE CASE OF AN EMERGENCY OR FOR URGENT REQUESTS FOR INFORMATION.

This authorization may be revoked at any time and must be done in writing. It is understood that the revocation will not apply to information that has already been released based on this authorization.

ACCEPTED: Signature: ______________________________ Date: __________

Printed Patient Name: ______________________________

Authorized E-mail of Individual: ______________________________

Cove Dental Care
Dr. Michelle Getz

NAME: ______________________ DOB: ___/___/___ SSN: ______-______-______

Address: ____
Street Apt/unit City State Zip

Home #: ____________ Work #: ____________ Cell #: ____________ Email: ________________

Please Circle: Sex: Male Female Please Circle: Minor* Single Married Divorced Widowed

Employer or School: ________________________________ Full Time: Y/N

Spouse or Parent*: ______________________ DOB: ___/___/___ SSN: ______-______-______

Employer: ______________________ Work #: ____________ Cell #: ____________

Other Responsible Party: ______________________ Relationship: ____________

Address: ____
Street Apt/unit City State Zip

Phone #: ____________ Phone #: ____________ DOB: ___/___/___ SSN: ______-______-______

Emergency Contact: ______________________ Phone #: ____________ Relationship: ____________

How did you learn about us? Location Phonebook Newspaper Family/Friend: ____________________

Insurance:
Insurance Company: ______________________ Phone #: ____________

Insured: ______________________ Relationship to Patient: ____________
Employer: ______________________ DOB: ___/___/___
SSN/ID: ____________

ACKNOWLEDGEMENT of NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability act of 1996 (HIPAA). 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 multiple healthcare providers who may be directly involved in that treatment

○ Obtain payment from third parties involved in payment (including family members and collections activities)

○ Conduct normal healthcare operations such as quality assessments

○ Notify me of treatment needs and appointments – by mail, phone, email

I have been informed that the **Notice of Privacy Practices** contains a more complete description of the uses and disclosures of my health information, and is available to me at any time by request. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this office at the address below to obtain a current copy of the **Notice of Privacy Practices**.

In addition to those mentioned above, my protected health information may be shared with: ____________

Patient Name ______________ **Signature of Patient** (or Representative) ____________

Representatives Relationship to Patient ____________ Date ____________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:
Reason:
Initials:

Cove Dental Care Medical History

Name: ____________________ **Name of Physician**: ________________ **PH. #** ____________

1. ALLERGIES: Penicillin/Antibiotics **Y/N** Anesthetics **Y/N** Metals **Y/N** Latex **Y/N**

   OTHER: ______________________________________

2. Do you take Asprin, Plavix, Coumadin, Pradaxa or other blood thinners? **Y/N** ____________
3. Do you need pre-medication before dental appointments? **Y/N** ________________
4. Do you have any Artificial Joints? What? ______________ When? __________
5. Do you take Osteoporosis medications? **Y/N** Name: ______________________
6. Do you take Viagra, Cialis or any other ED medications? **Y/N** ________________
7. Current Medications: _____________________________________

   ____

8. LIST ANY CURRENT MEDICAL PROBLEMS: ________________________________

Do you or have you ever had any of the following? Check **all** that apply:

Condition		Condition		Condition		Condition	
MVP/Heart Murmur		High Blood Pressure		Respiratory Problems		Sickle Cell/Blood Disorder	
Cardiac Pacemaker		Low Blood pressure		Tuberculosis		Acid Reflux Disease	
Heart Attack/Disease When?__________		Seizures or Fainting		Thyroid Disorder		HIV/AIDS	
Stroke/ TIA'S When?__________		Hepatitis: A B or C		Kidney Disease		Eating Disorder	
Rheumatic fever		Liver Disease		Cancer Type? __________		Alcoholism/ Drug Addiction	
Diabetes: TYPE 1 2 Controlled? Y / N A1C Level? ________		Stomach pain/ulcers		Chemo/Radiation		Depression/ Psychiatric Disorder	

Do you use tobacco products? Smoke Dip Chew How often?____________________

WOMEN

Are you pregnant? **Y / N** (____Weeks) Nursing? **Y / N** On birth control pills? **Y / N** On Hormone Replacement Therapy? **Y / N**

Reason for today's visit? ______________________________________

Date of last dental visit?______________________________________

Consent:

I understand x-rays, models, and other diagnostic tools/test may be necessary to make a thorough diagnosis of the patient's dental needs, and authorize the Doctor to obtain and/or perform any and all diagnostic procedure necessary. I authorize the release of protected health information to parties involved in payment for services rendered. I understand payment in full, or co-insurance is due when serves are rendered, and I am responsible for all fees associated with my account regardless of insurance coverage.

____________________________ _____________________ __________

Patient's Signature (Parent/Guardian if minor) Print name of Signatory Date

Michelle A. Getz, DMD

____________________________ __________

Doctor's Signature Date

FOR OFFICE USE:

DATE:		DATE:		DATE:	
BP:	PULSE:	BP:	PULSE:	BP:	PULSE: