Dr. Terry G. Box, DDS *Dr. Jenna Waselues, DDS*

PATIENT INFORMATION

Patient's Full Name: _____ **Preferred Name:** _____

Date Of Birth: ____/____/____ **Social Security #** ____-____-____ **Marital Status:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **E:Mail** _____

Emergency Contact: _____ **Number:** _____

How Did You Hear About Our Office? _____

RESPONSIBLE PARTY

Full Name: _____ **Relation To Patient:** _____

Date Of Birth: ____/____/____ **Social Security #** ____-____-____

Mailing Address: _____

Home Phone: _____ **Cell:** _____ **E:Mail** _____

INSURANCE INFORMATION

Dental Insurance Company: _____ **Employer:** _____

Name Of Policy Holder: _____ **Relation To Patient:** _____

Employer: _____ **Subscriber ID:** _____

Group Name: _____ **Group Number:** _____

Secondary Dental Insurance Company: _____ **Employer:** _____

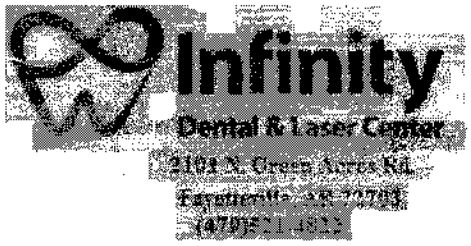
Name Of Policy Holder: _____ **Relation To Patient:** _____

Employer: _____ **Subscriber ID:** _____

Group Name: _____ **Group Number:** _____

Print Name: _____

Signature: _____ **Date:** _____



General Consent to Dental Treatment During COVID-19

Patient's Name: _____ Birthdate: _____ Chart #_____

Thank you for choosing our office for your dental needs. Our goal is to provide you with high quality dental care. The Arkansas Department of Health (ADOH) has recommended that dental facilities and healthcare providers may resume services that require minimal protective equipment on May 11, 2020. Because dental work often creates aerosols, it carries an added risk of spreading COVID-19. This form is being provided to you to identify potential risks of dental treatment during COVID-19. If you or a member of your household are experiencing symptoms of COVID-19 (e.g., fever, cough, shortness of breath), **please alert a member of our staff immediately**. We must be aware of such symptoms or any positive COVID-19 tests immediately to protect our dental office.

While all dental care has certain inherent risks and complications, patients face additional risks during the COVID-19 pandemic. These include, but are not limited to, increased risk of exposure to COVID-19. While we are taking all reasonable precautions to prevent the spread of COVID-19, it is impossible to eliminate that risk. Dentists and/or staff are exposed to multiple patients, who could be asymptomatic carriers of COVID-19. Complications of COVID-19 may include acute respiratory distress syndrome, irregular heart rate, cardiovascular shock, severe muscle pain, fatigue, heart damage or heart attack. The risk of complications is increased for individuals aged 65 and older, and individuals with compromised immune systems and/or chronic disease.

By signing this form, you acknowledge that in-person treatment for your dental condition presents increased risk of contracting COVID-19. You further acknowledge that for us to perform the treatment, we must be closer than the CDC recommended 6 ft. in proximity. You further agree that you will follow certain procedures as required by the ADOH, including but not limited to hand washing and wearing a surgical mask at certain times.

IF YOU EXPERIENCE ANY COVID-19 SYMPTOMS OR TEST POSITIVE FOR COVID-19 AFTER RECEIVING DENTAL TREATMENT, PLEASE CONTACT YOUR PRIMARY HEALTH CARE PROVIDER AND OUR DENTAL OFFICE IMMEDIATELY.

I give consent for myself/my child to receive dental treatment during the COVID-19 pandemic deemed necessary or recommended by the providers at this office.

This consent shall be considered in effect until rescinded or revoked.

_____ _____

(print your name) (relationship)

_____ _____

(Signature) (date)

MEDICAL AND DENTAL HISTORY (To be completed by the patient or legal guardian of the patient)

Patient's Full Name: _____ Male ☐ Female ☐

Date of Birth: _____ Age:_____

All past and current medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions (use bottom of page or other side if necessary). THANK YOU!

Below, please list all current medications including non-prescription medication you are taking and the reasons why you are taking them:

Medication Name:	**Dosage:**	**Condition Being Treated:**

Please list all drug allergies:

_____

_____

Please list all previous surgeries or hospitalizations and dates:

_____

_____

_____

Please Check "Yes" or "No" to the following Questions & Provide Additional Information as Needed in the Box or Below.

	YES	NO
1. High Blood Pressure		
2. Chest Pains/Angina		
3. Heart Attack Date(s):		
4. Stroke Date(s):		
5. Rheumatic Fever		
6. Shortness of Breath or Swollen Ankles		
7. Heart Trouble (circle or list other): -Heart Disease -Heart Failure -Murmur -Mitral Valve Prolapse -Other:		
8. Artificial / Prosthetic Devices in Heart (circle & date or list other): -Stent/ Valve- Date: -Pacemaker- Date: -Other: Date:		
9. Artificial / Prosthetic Joint (hip, shoulder, knee, etc.) -Location on Body: -Date:		
10. Asthma -Do you Require a Rescue Inhaler:		
11. Lung Diseases (circle or list other): -Tuberculosis - Emphysema - COPD - Chronic Cough - Other:		
12. Seasonal Allergies or Hay Fever		
13. Sinus Problems		
14. Stomach Ulcers or Stomach Problems		
15. Diabetes -Most Recent Hb A1C: Date: -Most Recent Blood Glucose: Date:		
16. Hepatitis (Please circle and list date of diagnosis) -A -B -C -Date of Diagnosis:		
17. Liver Disease or Liver Failure		
18. Kidney Disease / Failure / Dialysis		
19. Bladder Disease		
20. Thyroid Problems		
21. Connected Tissue Disease		
22. Sexually Transmitted Disease		
23. Arthritis or Rheumatism		
24. Cancer: -Type: -Date of Diagnosis: -Chemotherapy: -Radiation (how much):		
25. Subject to Prolonged Bleeding or Bruise Easily		
26. Wear Contact Lenses		
27. Glaucoma		
28. Hearing Impaired/ Wear Hearing Aids		
29. Epilepsy, Seizures, or Convulsions		
30. Anxiety / Depression		
31. Psychiatric, Mental or Emotional Health Issues		
32. Do you have HIV/AIDS (Tested positive for HIV) -Date of Diagnosis:		
33. Have you been exposed to HIV or Hepatitis B or C		
34. Have you been tested for HIV or Hepatitis B or C		
35. Anemia		
36. Adrenal Insufficiency		
37. Autoimmune Disorder(s) Type(s):		

	YES	NO
38. Blood Disease		
39. Blood Transfusion Problems or Rejected from Donating Blood Why:		
40. Chronic Fatigue or Night Sweats		
41. Fainting		
42. History of Taking Diet Drug Fen-Phen or Redux		
43. Have you Ever or are you Currently Taking Biophosphonates for Osteoporosis, Multiple Myeloma or other Conditions or Cancers? (ex: Fosamax, Boniva, Aredia) Please Explain:		
44. History of Infectious Endocarditis		
45. Immunosuppressed Disease Type(s): Date of Diagnosis:		
46. Low Blood Pressure		
47. Lymph Gland Enlargement or Tumor/Growth		
48. Malignant Hyperthermia		
49. Muscoskeletal Disorders Type(s): Date of Diagnosis:		
50. Nervous System Problem Type(s): Date of Diagnosis:		
51. Parkinson's Disease		
52. Peripheral Vascular Disease		
53. Pregnant or Possibly Pregnant Due Date:		
54. Currently Breast Feading/Nursing		
55. Taking Oral Contraceptives		
56. Drink Coffee		
57. Consume Tobacco -Type: -How much: - How many Years of Smoking: - Any Interest in Quitting:		
58. Consume Alcoholic Beverages How many Glasses/Week:		
59. Current or History of Recreational Drug Use		
60. History of Alcohol or Drug Abuse		
61. Pain, Popping, Catching or Locking Jaw Joints		
62. Clench or Grind your Teeth		
63. Wake up with Sore Jaws		
64. Frequent Headaches/migraines -How many per week:		
65. Dizziness, Ringing or Pain in Ears		
66. Tenderness or Stiffness in Jaw, Neck or Back		
67. Difficulty Opening or Closing your Mouth		
68. Difficulty Chewing		
69. History of TMJ (Jaw Joint) Problems or Therapy -Please Explain Problems: -Therapy:		
70. Interested in Whitening your Teeth		
71. Where a Removable Dental Appliance: Please List:		
72. Bite your Lips or Cheeks		
73. Hold Foreign Objects with your Teeth (Pen, etc.)		
74. Breathe Through your Mouth While Asleep		

	YES	NO		YES	NO
75. Snore			88. Halitosis (Bad Breath) or Unpleasant Tastes in your Mouth		
76. Do you have Sleep Apnea -Treatment/Therapy: _____			89. Bleeding Gums		
77. Have you ever been Tested for Sleep Apnea			90. Pain or Swelling of your Gums		
78. Treated for or Told you have Gum Disease			91. Food Catching between your Teeth		
79. Had Orthodontic Treatment/Therapy or Consulted for Orthodontic Treatment/Therapy Dates: _____ Treatment: _____			92. Shredding of Floss between your Teeth		
			93. Sore Teeth		
			94. Broken Teeth		
			95. Loose Teeth or Notice Loosening of Your Teeth		
80. Interested in Orthodontic Treatment			96. Tooth Sensitivity (Hot, Cold, Sweets, Etc.)		
81. Had your Bite Adjusted			97. Fever Blisters/ Cold Sores		
82. Had Oral Surgery Type(s): _____ Date(s): _____			98. Mouth Ulcers		
			99. Suck your Thumb, Finger or Lip (Now or in the Past?)		
			100. Tongue Thrusting Habit		
83. Dental X-Rays Taken in the Last Year			101. Gag Easily		
84. Dental Anxiety or Excessive Fear of Dental Treatment			102. Place a High Priority on Keeping your Natural Teeth		
85. Brush your Teeth How often: _____			103. Any Serious Illness Not Listed Above or any Condition Concerning your Health that the Doctor Should be Told Please List: _____ _____		
86. Floss your Teeth How often: _____					
87. Use a Waterpik® How often:					

Please expand on the above information (refer to the number) or add anything you feel is important:

_____

_____

_____

_____

_____

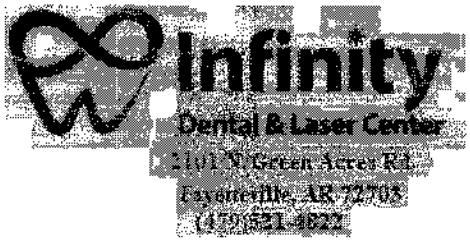
RELEASE STATEMENT

The above information is accurate and complete to the best of my knowledge. I authorize the dentists and health-care professionals at **INFINITY DENTAL AND LASER CENTER** to:

- Perform diagnostic procedures and treatment as necessary for proper care.
- Release of any information concerning mine or my child's health care for advice and treatment for the purpose of evaluation and administering claims for insurance benefits.
- Authorization of photographs, radiographs and other diagnostic records before, during and after treatment as well as the use of records for scientific presentations and/or literature.

Date:_____

Patient or Guardian's Signature:_____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement*

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

You may release my health information to the following individuals

_____

_____

_____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)