SCREENING FORM

Name (nombre): _____ Temperature (temperatura): _____°F

歯 Abe Dental Self-Declaration by Visitor, Patient, Employee

In an effort to reduce the risk of COVID-19 exposure to Abe Dental employees and patients, every visitor must complete the following screening questions. En un esfuerzo por reducir el riesgo de exposición a COVID-19 para los empleados y pacientes de Abe Dental, cada visitante debe completar las siguientes preguntas:

Part A – **Circle YES or NO**

Have you travelled out of state or country or had close contact with anyone who has traveled within the last 14 days? ¿Ha viajado en los últimos 14 días?	YES	NO
Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? ¿Ha tenido contacto cercano o ha cuidado a alguien diagnosticado con COVID-19 en los últimos 14 días?	YES	NO
Have you experienced any cold or flu-like symptoms in the last 14 days (fever, gastrointestinal upset, headache, cough, and shortness of breath or other respiratory problem)? ¿Ha experimentado algún síntoma similar al resfriado o la gripe en los últimos 14 días (fiebre, malestar gastrointestinal, dolor de cabeza, tos, falta de aliento u otros problemas respiratorios)?	YES	NO
Have you experienced recent loss of taste or smell? ¿Recientemente as experiment de perdida de holor, sabor?	YES	NO

Visitors answering yes to any of the above questions will be asked to withhold appointments onsite with Abe Dental and reschedule after following proper protocol as advised by a primary physician.

Part B (Primary Appointment) – **Circle YES or NO**

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? ¿Tienes un historial medico extensor y condiciones cardiacas, sistema inmunologico debil, como diabetes, problemas de rinon y pulmones etc??	YES	NO
Are you over 60 years old? *¿Tu edad es mas de 60 anos?*	YES	NO

Visitors who answered "yes" for Part B questions indicate a deeper discussion with doctor Abe before proceeding with appointments.

Visitor signature (Firma): _____ Date (Fecha): _____

ASSUMPTION OF THE RISK AND WAIVER OF LIABILITY RELATING TO CORONAVIRUS / COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

We want to assure you that **Abe Dental** has put in place comprehensive preventative measures based on the applicable state and federal regulations and protocols to reduce the spread of COVID-19 to you and that your risk of contracting COVID-19 is minimal. However, due to the very nature of dental practice, we cannot follow social distancing guidelines at all times while we are providing you treatment. Furthermore, we cannot guarantee that you will not become infected with COVID-19 while receiving care here at **Abe Dental**.

By signing this agreement, you acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that you may be exposed to or infected by COVID-19 during treatment. You also understand that the risk of becoming exposed to or infected by COVID-19 may result from the actions, omissions, or negligence of yourself and others, including, but not limited to, **Abe Dental** employees and other patients.

PATIENT / VISITOR ACKNOWLEDGEMENT:

I understand and voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to me that I may experience or incur in connection with my visit to, appointment with or treatment at **Abe Dental** (“Claims”). I hereby release, covenant not to sue, discharge, and hold harmless **Abe Dental**, its employees, agents, and representatives, and other patients of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of **Abe Dental**, its employees, agents, representatives and other patients. I also acknowledge that I could, or may have, exposure to COVID-19 outside of this office and unrelated to my visit(s) here.

_____ _____

Signature Date

_____

Printed name

REGISTRATION FORM

Please provide the following information:

PATIENT INFORMATION

NAME	Legal First Name MI Last		Date of Birth	Nickname
ADDRESS	Street Apt. No.		M M / D D / Y Y Y Y	Social Security
	City State Zip	Email		
CONTACT	Cell ☏	Home / Alternate ☏		
EMPLOYER	Employer Name	Work Phone		
STATUS	❑ Single ❑ Married ❑ Legally Separated ❑ Divorced ❑ Widowed	❑ Male ❑ Female ❑ Other:		Pronouns:
EMERGENCY CONTACT	Name	Relationship	Contact's Phone	
NEW PATIENT	❑ Yes ❑ No	General Dentist Name	Referred by	

Guardian or in care of, please complete this section:

GUARANTOR

NAME	First Name	MI Last		Social Security No.
ADDRESS	Street	Apt. No.	Guarantor birth date	Home Phone
	City	State Zip		Cell Phone
EMPLOYED?	Employer Name	❑ No ❑ Part-Time ❑ Full-Time ❑ Retired		Work Phone

In addition to filling out the information below, please also provide us with a copy of your dental insurance card.

DENTAL INSURANCE

DENTAL	Company Name		Insured Party
	Street		Relationship to patient
	City	State Zip	Insured's birth date
	ID NO. / POLICY NO.	GROUP NO.	Insurance Co. Phone No.
INSURED'S ADDRESS	Street	Apt. No.	Employer name
	City	State Zip	Insured's Phone No.
SECONDARY DENTAL	Company Name		Insured Party
	Street		Relationship to patient
	City	State Zip	Insured's birth date
	ID NO. / POLICY NO.	GROUP NO.	Insurance Co. Phone No.
INSURED'S ADDRESS	Street	Apt. No.	Employer name
	City	State Zip	Insured's Phone No.

MEDICAL INSURANCE

PRIMARY MEDICAL	Company Name		Insured Party
	Street		Relationship to patient
	City	State Zip	Insured's birth date
	ID NO. / POLICY NO.	GROUP NO.	Insurance Co. Phone No.
INSURED'S ADDRESS	Street	Apt. No.	Employer name
	City	State Zip	Insured's Phone No.

Date information taken:

_____/_____/_____

HEALTH HISTORY FORM

Patient Name:_____ Date of Birth:_____/_____/_____

For the following questions, please (x) all that apply; your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

MEDICAL INFORMATION

Clinical Staff Records Baseline BP: / P: SPO2:

Age:_____ **Sex:**_____

Height: _____ **Weight:**_____ lbs

Are you allergic to or have you had a reaction to any of the following? Please check all that apply.

❑ Local anesthetics	❑ Aspirin	❑ Latex	❑ Sulfa drugs
❑ Penicillin or other antibiotics	❑ Hay fever/seasonal	❑ Animals	❑ Iodine
❑ Barbiturates, sedatives, or sleeping pills		❑ Codeine or other narcotics	
❑ Metals (specify):_____			
❑ Food (specify):		❑ Other (specify):	

Are you taking any medications including non-prescription medication? Please list all medications:

_____

Past or present medical history, please check all of the following that apply:

❑ Heart murmur	❑ High blood pressure	❑ Low blood pressure	❑ Artificial heart valves	
❑ Congenital heart defects:	❑ Mitral valve prolapse	❑ Congestive heart failure		❑ Pacemaker
❑ Damaged heart valves disease/Rheumatic fever		❑ Heart attack	❑ Angina	
❑ Other coronary condition (specify):_____				
❑ Stroke	❑ Arteriosclerosis	❑ Other cardiovascular disease (specify):_____		
❑ Asthma	❑ Emphysema		❑ Bronchitis	❑ Tuberculosis
❑ Other respiratory condition (specify):_____				
❑ Kidney problems	❑ Hepatitis, jaundice or liver disease		❑ Abnormal bleeding	❑ Hemophilia
❑ Anemia	❑ Blood transfusion		❑ Fainting spells or seizures/Epilepsy	
❑ Neurological disorders (specify):_____				
❑ Type I (insulin dependent) Diabetes		❑ Type II Diabetes		
❑ Gastrointestinal disease:	❑ G.E. Reflux/persistent heartburn		❑ Ulcers	❑ Thyroid problems
❑ Mental health disorders	If yes, specify:_____			
❑ Osteoporosis	❑ Other Cancer/Chemotherapy / Radiation Treatment (specify):_____			
❑ Rheumatoid arthritis	❑ Arthritis	❑ Glaucoma	❑ Sinus trouble	
❑ Total joint (hip, knee, elbow, finger) replacement		❑ Systemic lupus erythernatosus		
❑ Sexually transmitted disease		❑ AIDS or HIV infection		
❑ **None of the above**				

List any major family medical history and relation to family member: *e.g.: cancer-mother, diabetes-father, high blood pressure-uncle*

_____

Have you had any surgery? If yes, what and when was this operation done?_____

If you use tobacco, how many packs per week? _____ **Alcohol consumption:** ❑Social:_____*drinks/week* ❑Daily ❑Never

If you use recreational drugs, please specify frequency:_____

If you are or were in a substance abuse program, please specify:_____

For women only: If you are or could be pregnant, how far along?_____ Nursing? ❑Yes ❑No

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient / Legal Guardian **Date**

For Clinical use only: ASA *MH updated:* _____/_____/_____ *Patient initial:*_____ *Dr. initial:*_____

_____

Dr. Signature Date

HIPAA FORM
PRIVACY ACKNOWLEDGEMENT

Federal law requires that we provide you with a copy of our Privacy Notice.

Please review **PRIVACY NOTICE** online at abedental.net or request and return the laminated copy in person. We will be happy to forward a digital copy to you or provide you a paper copy at your request. Please ask us!

The Privacy Notice explains how we may use and disclose health information about you.
We ask that you sign this form for our records so that we may document your receipt of the Notice.
If you have questions about the Privacy Notice, please refer to the contact information listed on the notice for Privacy Officer.

Patient Name (Print): _____ Date of Birth: ____/____/____

I have received a copy of the Privacy Notice for this organization on today's date:

_____

Signature **Date**

RELEASE OF INFORMATION DISCLOSURE

ROI: By naming trusted individual(s) below (*eg: Spouse, Parent, Child, Partner, Other*), I authorize Kyoko Abe DMD PC (DBA Abe Dental) to release information including but not limited to diagnosis, records, post-operative instructions; examination rendered to me and claims information. I authorize information to be released to individual(s) stated below:
Name(s) (First & Last):_____

Relation to Patient: _____

I consent to Abe Dental using my cell phone number to call or text regarding treatment, insurance and my account. I understand that
individual carrier rates may apply, and I can withdraw my consent at any time. Please mark ☒ all that apply:

☐My primary cell phone number to receive and reply to messaging is listed in registration
☐Alterate number for messaging:_____
☐I do not wish to or am unable to receive text messages.
☐Abe Dental may leave brief voice messages unless I provide alternate instructions

We use secure email methods to electronically communicate with our patients. Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in unencrypted email may be misdirected, disclosed or interrupted by unauthorized third parties. However, you may consent to receive unsecured email from us where we will use the minimum amount of protected health information necessary in any communication. Please mark ☒ all that apply.

☐Abe Dental's business email ☐Secure email portal ☐I do not wish to receive email communication.

You may revoke or make changes to this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement indicating that you are revoking this authorization to: Abe Dental 4401 SW Vermont Street, Portland, OR 97219. Unless revoked, this authorization expires in 24 months.

I have read this authorization and I understand it:

_____

Signature **Date**

Description of personal representative's authority _____

CHAPERONE FORM

Abe Dental Oral Surgery
4401 SW Vermont Street
Portland, OR 97219

GENERAL DENTIST
Practice Limited to
Oral Surgery
IV Sedation
&
Implantology

POST SEDATION COMPANION

1) Patient should not drive a motor vehicle for 24 hours after sedation.
2) DO NOT operate any hazardous devices / machinery for 24 hours after.
3) A responsible adult should be with the patient until patient is fully recovered from effects of the sedation.
4) Patient should not go up and down stairs unattended. Whenever possible, have the patient stay on the first floor until recovered.
5) Unless otherwise recommended, the patient should resume normal eating and drinking after sedation appointment, with attention to a softer food diet and drinking plenty of water to stay hydrated.
6) After leaving the office, the patient should not be left unattended. The effects of the medications can last several hours after the appointment has ended. Do not allow the patient to make important decisions for the remainder of the day following their appointment.
7) Do not take any medications unless those prescribed or discussed with your doctor.
8) Avoid recreational drug use, and do not drink alcohol including hard liquor, beer and wine.
9) Always hold patients arms when walking as they may have problems with balance while under the effects of sedative medications.
10) Call the office if you have any questions or concerns: **(503) 297-4102**.

If patient's symptoms warrant a physician and you are unable to reach us, go to the nearest emergency room immediately.
Following most surgical procedures there may or may not be pain. The patient will be provided with medication for discomfort that is appropriate for them. In most cases, a non-narcotic pain regimen is recommended consisting of acetaminophen, not to exceed 4000 mg a day – please be aware pain medication normally includes acetaminophen. Ibuprofen can be taken regularly as prescribed or recommended, not to exceed 2400 mg a day. These two medications can be TAKEN TOGETHER to reduce inflammation and manage pain. Be sure to follow directions carefully and with any adverse reactions discontinue medications and call Dr. Abe right away.

Patient Name: _____

Companion Name: _____ Relation To Patient: _____

Companion Signature: _____ Date: _____

Companion Cell Phone Number: _____