Dr. Eran Arvilli DDS
1636 Montauk Hwy. Suite #3 Mastic, New York 11953
631-772-7379

CONSENT TO DENTAL TREATMENT

I, (Print Name)_____have been informed by Dr. Arvilli, of the need to undergo dental treatment as presented to me on (Date)_____

I have been fully informed about the details of the recommended treatment and alternatives, and agree to accept the terms as recommended by the doctor.

I understand that as the treatment proceeds there r:-.ay be need to change the treatment plan. If this occurs I expect to be informed before any change is instituted.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible.

I have discussed all of the above with the doctor, and all my questions have been answered.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

Following the explanations, the discussion, and the answers to my questions, I authorize the doctor to complete the treatments described.

_____ _____

Patient Signature If Minor, Signature of a Parent or Guardian

_____ _____

Witness Signature Doctors Signature

_____

Date

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PATIENT ADVISORY AND ACKNOWLEDGMENT/ INFORMED CONSENT
RECEIVING DENTAL TREATMENT INTHE ERA OF COVID-19

Dear Patient,

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", as at any time or in any place. Be assured that we have always complied with the S1ate Department of Health and the Centers for Disease Control and Prevention infection control guidelines to limit transmission of all diseases and continue to do so.

Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dentist, dental staff and sometimes other patients at all times.

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. For the safety of our staff, other patients and yourself, please be truthful and candid in your answer.

Date :_____

Patient Name: Date of Birth:_____

_____

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

Do you or the patient(s) have a runny nose? Yes No

Do you or the patient{s) have a fever or felt hot or feverish recently? (14-21 days} Yes No

Do you or the patient(s) have a sore throat? Yes No

Do you or the patient(s) have a dry cough? Yes No

Have you or the patient(s) had a reduction in your sense of smell or taste? Yes No

Have you or the patient(s) experienced shortness of breath or had trouble breathing? Yes No

Have you or the patient(s) been tested for COVID-19 and are awaiting results? Yes No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? Yes No

Do you or the patient(s) have a heart, lung or kidney disease, diabetes or any auto-immune disorders? Yes No

Have you or the patient(s) been in contact with someone who has tested positive for COVID-19? Yes No

Do you have a sick family member at home with COVI0-19? Yes No

Have you traveled outside of the United States by air or cruise ship In the past 14 days? Yes No

Have you traveled within the United States by air, bus or train within the past 14 days? Yes No

Have you tested positive COVID-19? Yes No

☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this Covid-19 questionnaire and responded accordingly. There are no other medical conditions. I am aware that I must notify the practice of any future changes.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act- 45 CFR Parts 160 and 164)

I hereby authorize_____to use and/or disclose the
..[Name of Health Care Provider]
protected health information described below to_____
[Name of Individual]

2. Authorization for Release of Information. Covering the period of health care from

☐_____to _____ **OR** ☐ all past, present and future periods:

a. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol and/or drug abuse).

OR

b. I hereby **authorize the release of my complete health record with the exception of the following information:**

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until----------at which time this authorization expires.
[Date or Event]

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

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Welcome

Patient Registration Form

Patient's Name:_____Date:_____
Last First Middle Initial

Address: _____

City:_____State:_____ Zip: _____

Home Phone: (____)_____Work Phone: (____)_____Cell Phone: (____)_____

_____

Employment Information:

Name of Employer: _____

Employer Address: _____

Present Position:_____How long: (years)_____(months)_____

Dental Insurance Name:_____Group #:_____Local #:_____

Insurance Address: _____

Social Security Number:_____ Date of Birth:_____Driver's Lic.#: _____

MARITAL STATUS: □ Single □ Married □ Widowed □ Other _____

Dental Information

1. How long has it been since your last dental visit?

   □ Less than 6 months □ 6 months □ 1 year □ 2 years □ Over 2 years

2. Why did you leave your last dentist?

   □ I moved □ Did not have my interests in mind □ I had financial problems within the office

   □ The dentist moved □ Did not explain things □ Unresolved problems with office

   □ I always had to wait □ Was not gentle □ Prefer not to say

   □ Inconvenient hours □ Office staff was uncaring

3. Why did you choose to come in at this time?

□ General Checkup □ I have areas of pain

□ I have broken fillings or teeth □ I've put it off too long □ Other _____

4. How would you describe the general condition of your teeth?

□ Excellent □ Good □Fair □ Poor

5. If you could change the appearance of your teeth, what would you change?

□ Color □ Crowding or crooked teeth □ Black discolored filling □Other _____

6. Do you believe that having your teeth cleaned regularly will help prevent gum disease, and thereby prevent you from losing your teeth? □ Yes □ No

7. Do you smoke a pack or more of cigarettes a day? □ Yes □ No

8. Do you believe dental disease is avoidable? □ Yes □ No

9. Are you apprehensive about your visit here? □ Yes □ No

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AUTHORIZATION TO PAY BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED,_____
FOR DENTAL BENEFITS. OTHERWISE MADE PAYABLE TO ME FOR DENTAL SERVICES PROVIDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS AUTHORIZATION.

DATE:_____SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT: _____

Health History

Name_____ Home Phone_____Business Phone_____
Address_____City_____State_____Zip code_____
Occupation_____Height_____Weight_____ Date of Birth ___/___/____Sex □ M □ F
Emergency Contact_____ Relationship_____ Phone (____)_____
If you are completing this form for another person, what is your relationship to that person? _____
Name Relationship

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please not 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.

Dental Information

Yes	No	Don't Know		Yes	No	Don't Know	
□	□	□	Do your gums bleed when you brush?	□	□	□	Have you ever had orthodontic (braces) treatment?
□	□	□	Have you had any periodontal (gum) treatments?	□	□	□	Do you have headaches, earaches or neck pains?
□	□	□	Do you wear removable dental appliances?	□	□	□	Are your teeth sensitive to cold, hot, sweets or pressure?

□ □ □ Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain

_____

How would you describe your current dental problem? _____
Date of your last dental exam_____Date of last dental X-Ray _____
What was done at that time? _____
How do you feel about the appearance of your teeth? _____

Medical Information

Yes No Don't Know

□ □ □ Are you in good health?
□ □ □ Has there been any change in your general health within the past year? Do you have any of the following diseases or problems:
□ □ □ Active Tuberculosis
□ □ □ Persistent cough greater than a 3 week duration
□ □ □ Cough that produced blood
□ □ □ Are you under the care of a physician? If so, what is /are the condition(s) being treated? _____
Physician(s)_____
Name Phone Address
□ □□ Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem?

_____

□ □ □ Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking? _____
□ □ □ Are you taking, or have you taken, any diet drugs such as Pondimin (fendiuramine), Reduz (dexphenfluramine) or phen-fen(Phentermine)?
□ □ □ Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours?_____In the past month? _____
If yes,_____# of drinks per day for_____ # of years
□ □ □ Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) □ Yes □ No
□ □ □ Do you use drugs or other substances for recreational purposes? If yes, please list_____
Frequency of use (daily, weekly, etc.)_____ Number of years of recreational drug use_____
□ □ □ Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) □ Very □ Somewhat □ Not
□ □ □ Do you wear contact lenses?

Allergies – Are you allergic to or have you had a reaction to: (please fill out both columns)

Yes	No	Don't Know		Yes	No	Don't Know	
□	□	□	Local anesthetics	□	□	□	Latex
□	□	□	Aspirin	□	□	□	Iodine
□	□	□	Penicillin or other antibiotics	□	□	□	Hay fever/seasonal
□	□	□	Barbiturates, sedatives, or sleeping pills	□	□	□	Animals
□	□	□	Sulfa drugs	□	□	□	Food (Specify)_____
□	□	□	Codeine or other narcotics	□	□	□	Other (Specify)

_____
To yes responses, specify type of reaction _____

Yes No Don't Know

□ □ □ Are you pregnant?
□ □ □ Nursing?
□ □ □ Taking birth control pills?
□ □ □ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done? _____
□ □ □ Have you ever had any complications or difficulties with your orthopedic joint?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose, and what reason?_____

Name of physician or dentist*_____Phone _____

Please (x) if you have or had any of the following diseases or problems.

Yes No Don't Know

□ □ □ Abnormal bleeding
□ □ □ AIDS or HIV induced immunosuppression
□ □ □ Anemia
□ □ □ Arthritis
□ □ □ Rheumatoid arthritis
□ □ □ Asthma
□ □ □ Blood Transfusion
If yes, date_____
□ □ □ Cancer/chemotherapy
Radiation treatment
□ □ □ Cardiovascular disease
If yes, specify
O Angina
O Arteriosclerosis
O Artificial heart valve
O Coronary insufficient
O Damages heart valves
O Heart attack
O Heart murmur
O High blood pressure
O Inborn heart defects
O Mitral valve prolapse
O Pacemaker
O Rheumatic Heart disease
□ □ □ Chest pain upon exertion

Yes No Don't Know

□ □ □ Disease, drug or radiation
If yes, specify _____
□ □ □ Diabetes, if yes specify type
□ □ □ Dry mouth
□ □ □ Eating disorder
□ □ □ Epilepsy
□ □ □ Fainting spells or seizures
□ □ □ G.E. reflux
□ □ □ Glaucoma
□ □ □ Hemophilia
□ □ □ Hepatitis, jaundice or liver disease
□ □ □ Recurrent infections
Indicate type of infection
_____
□ □ □ Kidney problems
□ □ □ Low blood pressure
□ □ □ Mental health disorders
If yes, specify below:
_____
_____
□ □ □ Malnutrition
□ □ □ Migraines
□ □ □ Night sweats

Yes No Don't Know

□ □ □ Neurological disorders
□ □ □ Osteoporosis
□ □ □Persistent swollen glands in neck
□ □ □ Respiratory problems
□ □ □ Severe headaches
□ □ □ Severe or rapid weight loss
□ □ □ Sexually transmitted diseases
□ □ □ Sinus trouble
□ □ □ Sleep disorder
□ □ □ Sores or ulcers in the mouth
□ □ □ Stroke
□ □ □ Systemic lupus erythematosus
□ □ □ Thyroid problems
□ □ □ Tuberculosis
□ □ □ Ulcers
□ □ □ Excessive urination
□ □ □ Do you have any disease, conditions, or problem not listed above that you think I should know about? Please explain:
_____

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 completion by dentist

Comments on patient interview concerning health history_____

_____

Significant findings from questionnaire or oral interview _____

_____

Dental management considerations_____

_____

Signature of Dentist Date