THE
DENTURE CENTER

Dr. Jeetendra Patel, DDS
1655 Louisville Avenue
Monroe, LA 71201

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that is maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

COVID-19 Pandemic
Patient Disclosures Form

THE DENTURE CENTER

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

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 we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry 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 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 by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____

Witness

THE DENTURE CENTER

COVID-19 Pandemic
Emergency Dental Treatment
Notice & Acknowledgement of Risk Form

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

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 create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non-essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are "potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection." The ADA also recommends that urgent dental care which "focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments" be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

Signature Date

_____

Witness

THE DENTURE CENTER

PATIENT HISTORY INFORMATION

Patient ID #
For office use:

Name:_____
(first name) (middle name) (last name)

Sex: ____M____F **Date of Birth:** _____/_____/_____ **Social Security Number:** _____ - _____ - _____

Street Address:_____

City:_____ **State:**_____ **Zip:**_____ **E-Mail:** _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Emergency Contact Name & Phone:_____

Race: ___**African American** ___**Asian American** ___**Caucasian/White** ___**Hispanic** ___**Other**

Name of Family Physician: _____ **City:**_____ **State:**_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What is your reason for today's visit?_____

1. **Have you received treatment in our office previously?** ❑ YES ❑ NO **If yes, when?** _____
2. **What specific communication led you to choose The Denture Center today?** (check one)

❑ Magazine ❑ Newspaper ❑ Radio ❑ Billboards/Sign ❑ Brochure/Mail ❑ Television
❑ Yellow Pages ❑ Friend/Relative ❑ Internet/Web Site ❑ Other Doctor ❑ Outside Agency

3. **Did you call our toll-free information service (1-888-DENTURE)** ❑ YES ❑ NO

Do you have commercial dental insurance? ❑ YES ❑ NO **Name of insurance:**_____
Speak with our front desk regarding options to utilize your insurance benefits.

Are you currently wearing dentures? ❑ YES ❑ NO **If yes, when did you receive your last dentures?**_____

Have you taken, are you taking or are you scheduled to begin taking medications for osteoporosis?
❑ Oral Bisphosphonates: (Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid))?
❑ Intravenous Bisphosphonates: (Clodronate (Bonefos), Pamidronate (Aredia) or Zoledronic Acid (Reclast, Zometa))?
❑ Prolia (Denosumab)?

Do you use or have you used tobacco products? (circle Past or Currently per relevant mark)
❑ Smoking (Past/Currently)
❑ Snuff (Past/Currently)
❑ Chew (Past/Currently)
❑ Bidis (Past/Currently)
❑ Vaping (Past/Currently)

Do you drink alcoholic beverages?
❑ YES ❑ NO ❑ DK

If Yes, are you alcohol dependent?
❑ YES ❑ NO ❑ DK

Do you use or have you used prescription or street drugs or other substances for recreational purposes? (circle Past or Currently per relevant mark)
❑ Cocaine (Past/Currently)
❑ Ecstasy (Past/Currently)
❑ Heroin (Past/Currently)
❑ Marijuana (Past/Currently)
❑ Methamphetamine (Past/Currently)
❑ Oxycontin (Past/Currently)
❑ Other:_____ (Past/Currently)

If Yes, are you Drug dependent?
❑ YES ❑ NO ❑ DK

Females only - Are you pregnant?
❑ YES ❑ NO ❑ DK
If yes, how many weeks: _____

Are you nursing?
❑ YES ❑ NO ❑ DK

Are you taking birth control pills, fertility drugs or hormonal replacement?
❑ Birth Control
❑ Fertility Drugs
❑ Hormonal Replacement

Allergies:
Are you allergic to or have you had a reaction to any of the following?
❑ Local anesthetics (Novocaine, Lidocaine)
❑ Penicillin
❑ Sulfa drugs
❑ Aspirin
❑ Codeine or other narcotics
❑ Hay fever/ Seasonal (allergic rhinitis)
❑ Metals/ Jewelry (nickel, chrome)
❑ Iodine
❑ Latex (rubber)
❑ Food/Other:_____

Specify type of Reaction: _____
_____

<CONTINUED>

MEDICATIONS

Are you taking, have you recently (within the last month) taken, or are you supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural or herbal)? ❑ YES ❑ NO ❑ DK

If yes, specify medication(s), dosage and frequency:

Medications Prescription / Over Counter	Dosage / Frequency	Supplements Diet Supplements, Vitamins (natural or herbal)	Dosage / Frequency

Do you take Blood Thinners Daily: ❑ YES ❑ NO ❑ DK If yes, circle: Coumadin Xarelto Plavix Other:_____

Medical Conditions

Heart/Blood Pressure problem
Y N
- ❑ ❑ Rheumatic fever/ Rheumatic heart disease
- ❑ ❑ Infective endocarditis
- ❑ ❑ Artificial heart valves
- ❑ ❑ Congenital heart defect
- ❑ ❑ Heart murmur
- ❑ ❑ Mitral valve prolapse
- ❑ ❑ Angina (chest pain)
- ❑ ❑ Heart attack date of most recent
- ❑ ❑ Heart failure
- ❑ ❑ Coronary heart disease
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Palpitations
- ❑ ❑ Arrhythmia (irregular heart beat)
- ❑ ❑ Shortness of breath
- ❑ ❑ Swelling of the ankles
- ❑ ❑ Pacemaker
- ❑ ❑ Implantable defibrillator
- ❑ ❑ Other: _____

Respiratory/Lung problem
Y N
- ❑ ❑ Asthma
- ❑ ❑ Emphysema/ COPD
- ❑ ❑ Tuberculosis
- ❑ ❑ Sinusitis
- ❑ ❑ Bronchitis
- ❑ ❑ Persistent Cough
- ❑ ❑ Sleep Apnea
- ❑ ❑ Snoring
- ❑ ❑ Other: _____

Diabetes/Endocrine Disorder
Y N
- ❑ ❑ Diabetes
  - Type 1
  - Type 2
- ❑ ❑ Thyroid Problems
  - Hypothyroidism
  - Hyperthyroidism
- ❑ ❑ Other: _____

Kidney/Urinary disorder
Y N
- ❑ ❑ Renal failure/insufficiency
- ❑ ❑ Dialysis
- ❑ ❑ Frequent urination
- ❑ ❑ Other: _____

Cancer or Tumors
Y N
- ❑ ❑ Malignant

Location:_____
_____

- ❑ ❑ Benign

Location:_____
_____

Neurologic/Nerve problem
Y N
- ❑ ❑ Stroke date of most recent
- ❑ ❑ TIA (Transient ischemic attack)
- ❑ ❑ Seizures/Epilepsy
- ❑ ❑ Multiple sclerosis
- ❑ ❑ Parkinson's disease
- ❑ ❑ Neuropathies
- ❑ ❑ Dementia/Alzheimer's (memory loss)
- ❑ ❑ Headaches
- ❑ ❑ Fainting or dizzy spells
- ❑ ❑ Feeling of tingling or numbness
- ❑ ❑ Psychiatric disease/Mental health disorder
- ❑ ❑ Bipolar/Manic depression
- ❑ ❑ Schizophrenia
- ❑ ❑ Depression
- ❑ ❑ ADD/ADHD (attention deficit disorder)
- ❑ ❑ Feelings of anxiety
- ❑ ❑ Feelings of depression
- ❑ ❑ Other: _____

Blood/Hematologic disorder
Y N
- ❑ ❑ Anemia
- ❑ ❑ Sickle cell disease
- ❑ ❑ Sickle cell trait
- ❑ ❑ Bruise easily
- ❑ ❑ Leukemia
- ❑ ❑ Lymphoma
- ❑ ❑ Bleeding disorders
- ❑ ❑ Hemophilia
- ❑ ❑ Other: _____
- ❑ ❑ Other: _____

Stomach/Intestine/Liver disorder
Y N
- ❑ ❑ Cirrhosis/Chronic hepatitis
- ❑ ❑ Jaundice (skin/eyes turn yellow)
- ❑ ❑ Hepatitis: A B C D
  Other: ____ Circle one
- ❑ ❑ Heartburn
- ❑ ❑ Acid reflux (GERDS)
- ❑ ❑ Ulcers
- ❑ ❑ Crohn's disease
- ❑ ❑ Other: _____

Muscle/Bone/Connective Tissue disorder
Y N
- ❑ ❑ Arthritis
  - Rheumatoid
  - Osteoarthritis
  - Other: _____
- ❑ ❑ Osteoporosis
- ❑ ❑ Gout
- ❑ ❑ Temporomandibular joint disorder
- ❑ ❑ Lupus
- ❑ ❑ Fibromyalgia
- ❑ ❑ Other: _____

Infectious Disease
Y N
- ❑ ❑ HIV
- ❑ ❑ Aids
- ❑ ❑ STD (sexually transmitted disease)
  - Syphilis
  - Gonorrhea
  - Chlamydia
  - Genital herpes
  - Human papillomavirus
- ❑ ❑ Cold sores
- ❑ ❑ Other: _____

Head/Eyes/Ear/Nose/Throat problem
Y N
- ❑ ❑ Vision problems
- ❑ ❑ Glaucoma
- ❑ ❑ Hearing impairment
- ❑ ❑ Other: _____

Dermatologic/Skin problem
Y N
- ❑ ❑ Specify: _____
  _____

Eating disorder
Y N
- ❑ ❑ Bulimia
- ❑ ❑ Anorexia
- ❑ ❑ Other: _____

Do you have any other problem, not listed above?

_____
_____
_____

Is a Medical Consult Necessary:
- ❑ **Yes**
- ❑ **No**

Patient Name: _____ **Date:** ____/____/____

OUR PAYMENT POLICY

We gladly accept payment by cash, check, American Express, MasterCard, Visa and Discover.