ENDODONTIC
ASSOCIATES
OF ALBUQUERQUE

Please Print

Patient Name: _____ Today's Date: _____

Address: _____

City, State, Zip Code: _____

Home #: _____ Cell #: _____

Email: _____

Social Security #:_____Date of Birth: _____

Parent/Guardian (if minor): _____

Name of Referring Dentist: _____

Primary Insurance Information

Insurance Co: _____ Phone #: _____

Subscriber Name: _____Employer: _____

Subscriber Social Security #:_____ Date of Birth: _____

I, _____ consent to an exam and x-rays to diagnose my chief complaint.

Patient Signature/Guardian: _____Date: _____

Endodontic Associates of Albuquerque

Health History

Patient:_____Age:_____Date:_____
What is your chief concern:_____
Are you currently under the care of a physician? **Y** or **N** _____
Physician's Name:_____
Do you have or have you ever had any of the following:

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Shortness of Breath
- ☐ Chest Pains
- ☐ Liver Problems
- ☐ Hepatitis
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Severe Headaches
- ☐ Seizures
- ☐ Stomach Ulcers
- ☐ Kidney Problems
- ☐ Cancer
- ☐ Radiation/Chemotherapy
- ☐ Psychiatric Care
- ☐ Fainting Tendency
- ☐ HIV/AIDS
- ☐ Hip/Joint Replacement
- ☐ Lung Problems/Asthma
- ☐ Sinus Problems
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Systemic Lupus
- ☐ Latex/Rubber Allergy
- ☐ Treatment with Steroids
- ☐ Organ Transplant
- ☐ Currently Pregnant

Do you have any other problems not listed above? **Y** or **N**
If yes, what?_____

Are you taking or have you ever taken any bone replacement, cancer or osteoporosis medication? **Y** or **N**. If yes, please list:_____

Are you allergic to Latex? **Y** or **N**

Are you allergic to any medications? **Y** or **N**. If yes, please list:_____

Please List any medications you are taking at this time:_____
_____

The above information is true to the best of my knowledge. I have also had the opportunity to review the Notice of Privacy Policies.

Signature:_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Endodontic Associates of Albuquerque

- You may refuse to sign this acknowledgement

I have reviewed a copy of this office's Notice of Privacy Practices.
(3 ring binder located in office lobby)

_____

Please Print Patients Name

_____

Patients, Parent or Guardian's Signature

Date: _____

Authorize release of information to: _____

_____

FOR OFFICE USE ONLY

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

☐ Individual Refused to Sign.

☐ Communication barriers prohibited us from obtaining the acknowledgment.

☐ Other (Please specify)

_____

ENDODONTIC
ASSOCIATES
OF ALBUQUERQUE

COVID-19 Pandemic Emergency Dental Treatment Consent Form

I, _____ , knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic.

This office meets or exceeds all current CDC, FDA, ADA, and New Mexico Dept. of Health regulations involved in disinfection, social distancing, and staff testing and regulation related to the virus.

I understand the virus that causes COVID-19 has a long incubation period, during which carriers of the virus may now show symptoms and still be highly contagious. Given the current limitations of viral testing, it is impossible to determine who is carrying the virus, and who is not.

Dental procedures procedure water spray, which is considered to be one of the vectors by which the virus may spread. The ultra-fine nature of the spray may linger in the air for several minutes after the procedure is completed, and is hypothesized as a vector by which the virus may be spread.

- I understand that due to the frequency of dental visits of other patients, the characteristics of the virus, and the characteristics of necessary, emergency dental procedures, that I have an elevated risk of contracting the virus simply by being in any dental office. _____ (initial)
- I have been made aware of the CDC, NMDA, and ADA guidelines that, under the current pandemic, all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, and conditions that significantly inhibit normal operation of the teeth and mouth. _____ (initial)
- I confirm I am seeking treatment for a condition that meets the above criteria _____

I confirm that I am not presenting with any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of breath
- Dry cough
- Runny nose
- Sore throat
- _____ (initial)

I verify I have not traveled outside of the United States in the past 14 days to countries or to other states that have been affected by COVID-19. _____ (initial)

I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____ (initial)

Name: _____ Date: _____