Fitzpatrick Dental
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FITZPATRICK
DENTAL

COVID-19

Risk Screening Flowchart to Identify the Coronavirus (COVID-19)

Patient Name: _____ **Date:** _____ **Temp:** _____

1. Have you traveled outside or inside the U.S. or been on a cruise in the last 21 days?
   ○ No
   ○ Yes When?_____

Area(s) Traveled

- China
- Iran
- Italy
- Japan
- South Korea
- Other _____

2. Have you been in direct contact with someone diagnosed with the Novel Coronavirus?
   □ No
   □ Yes When?_____

3. Do you have any of the following symptoms? (Corona Screening)
   - None
   - Yes
     - Fever of 100 or higher
     - Dry cough
     - Fatigue
     - Sputum production
     - Shortness of breath
     - Flu-like symptoms
     - Muscle pain or joint pain
     - Sore throat
     - Vomiting, diarrhea, stomach pain

SUPPLEMENTAL INFORMED CONSENT

Dental Treatment in the Era of COVID-19

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", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you can be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social distancing" nationwide has reduced the transmission of Coronavirus. 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, Dental providers, Dental staff, and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

☐ Yes ☐ No

_____

Patient Name

_____ _____

Parent/Guardian Name (if applicable) Relation

_____ _____

Patient/Parent/Guardian Signature Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

ROBERT J. FITZPATRICK, DDS
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