## PATIENT INSURANCE INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.

---

Patient's Name _____ Today's Date _____

Sex _____ Age _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____

Home Phone _____ E-Mail _____

Emergency Contact _____

Responsible Party's Name _____

Relationship to Insured _____

Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Address _____

City _____ State _____ Zip _____

Dental Insurance _____ ID Number _____

Medical Insurance _____ ID Number _____

Referring Dentist _____ Physician _____

Orthodontist _____

Reason for visit _____

Family members who have been patients here _____

# John F. Coyne, D.M.D
# Southeastern Oral & Maxillofacial Surgeons

## HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Date _____

All responses are kept confidential

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? .. ..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe:.... Y N

   _____ _____

   _____ _____

6. Height ____ Weight ____
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Rheumatic Fever or Rheumatic Heart Disease? Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? .. ..... Y N
   - I. Diabetes? ..... ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... ..... Y N
   - N. Osteoporosis ..... ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .... Y N
9. ARE YOU USING ANY OF THE FOLLOWING:
   - A. Antibiotics? ..... ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ... ..... Y N

G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
H. Digitalis, Inderal, Nitroglycerin or other heart drug?. ....Y N
I. Are you taking or *have you ever taken* Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa) ? ..... Y N
J. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:

_____

_____

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   A. Local Anesthesia (Novocain, etc.)?..... Y N
   B. Penicillin or other antibiotics?..... Y N
   C. Sedatives, Barbiturates? ..... Y N
   D. Aspirin or Ibuprofen?..... Y N
   E. Codeine or other pain killers? ..... Y N
   F. Latex or Rubber Products? ..... Y N
   G. Other allergies or reactions? Please, list..... Y N

_____

_____

10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia?Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. FOR WOMEN ONLY
    A. Are you Pregnant, or <u>Is there any chance</u> you might be Pregnant? ..... Y N
    B. Are you nursing? ..... Y N
    C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

_____ X _____ _____
Date Signature of Person Completing Health History Doctor's Initials

Medical Update: I have ready my Health History dated _____ and confirm that it adequately states past and present conditions.

| Date | Exceptions or changes | Patient's Signature | Doctor's Initials |
|---|---|---|---|
| | | | |
| Date | Exceptions or changes | Patient's Signature | Doctor's Initials |

# COVID-19 PANDEMIC - PATIENT DISCLOSURES

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

# COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT

## NOTICE AND 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

SOUTHEASTERN
*Oral & Maxillofacial Surgeons*
**John F. Coyne, D.M.D**

**951 N. Main Street**
**Brockton, MA**
**Ph 508-588-0200**
**Fax 508-583-6456**

## Financial Arrangements

Our office has established procedures that maintain quality care and reasonable costs for our patients. Fees for your consultation and x-ray interpretation are due at your first appointment. We will be happy to discuss these terms and financial arrangements for your treatment with you during your visit.

You will be given a detailed estimate of the surgery treatment fees after the consultation appointment. The fees quoted are an estimate only. If the procedure proves to be more complex than anticipated, the fees will be adjusted accordingly. The stated fees will be honored for a period of 90 days.

Since we want to keep our fees as low as possible, payment on the day of treatment is required. For your convenience, we accept cash, personal checks, Visa, Mastercard, and Discover. We also offer CareCredit, a dental charge card, for which you can apply at the time of your visit.

### Your Insurance Coverage

We must remind our patients that insurance is a method of reimbursement, not a substitute for payment. While dental plans offer assistance, they rarely cover the entire fee. You have the financial obligation for treatment. Please be aware that each dental plan independently determines the maximum fee allowance for each type of service. If you have insurance, we require your co-payment at the time of surgery. The balance is due 45 days later. Upon receipt of your company's dental plan payment, we will refund any credit or bill the balance to you.

We will assist you in properly filing your claim. You must understand that insurance coverage is a contract between you and the insurance company not between the insurance company and the doctor. Our services are provided to you, the patient, and not your dental plan. That is, you, and not the dental plan, are responsible for the account.

## Financial Policy

I,_____, acknowledge that I am responsible for payment of all fees in association with my treatment. Patients without insurance will be required to pay prior to treatment. We accept cash, checks, Visa, Mastercard, Discover, and American Express. We also have payment plans through CareCredit. If you do not have insurance, the contract is between the insurance company and you, and not with Dr. Coyne and Southeastern Oral and Maxillofacial Surgeons, P.C. As a courtesy, our office will assist you in any way possible with the processing of your insurance. It is your responsibility to provide us with accurate information. Any co-payments and insurance deductibles will be paid prior to treatment. You are also required to pay any balances due if your insurance does not cover your treatment in full or refuses to pay. Overdue accounts will be charged a late fee of 1-1/2% per month on outstanding balances. If checks are processed with insufficient funds to cover them, a fee of $50.00 will be added to your account. If you miss a scheduled appointment without calling 24 hours in advance, you will be billed a fee of $65.00. Exceptions may be made for extenuating circumstances at the discretion of Dr. Coyne.

I acknowledge that I have read the financial policy of Dr. Coyne and Southeastern Oral and Maxillofacial Surgeons, P.C. and agree with the terms. I have had the opportunity to discuss this with Dr. Coyne or the staff. I further acknowledge that I am responsible for all financial obligations associated with treatment, even if I have insurance coverage. The information provided is accurate to the best of my knowledge.

Patient Signature:_____ Date:_____
Witness Signature:_____ Date:_____

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

Name: _____

Address: _____

Telephone: _____ E-mail _____

Patient #: _____

**SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr John F. Coyne, D.M.D.

Telephone: 508-588-0200 Fax: 508-583-6156

E-mail: JFCOMFS@AOL.COM

Address: 951 North Main Street, Brockton, MA 02301

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**Include completed Consent in the patient's chart.**

Southeastern Oral & Maxillofacial Surgeons

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____. have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature _____

Date _____

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

# TOOTH EXTRACTION INFORMED CONSENT

Patient's Name _____ Date of Birth _____

This form and your discussion with your doctor are intended to help you make informed decisions about your surgery. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all of the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Diagnosis: Non-Restorable Tooth/Teeth

Procedure: Extraction of tooth/teeth #'s:

Alternative options: No Treatment, Root canal treatment

1. I have been informed of and understand the potential risks related to this surgical procedure include but are not limited to:
    - Pain, swelling, bleeding, infection, bruising, delayed healing, scarring, damage to other teeth and/or roots that may result in the need for tooth repair or loss, loose tooth/teeth, damage to dental appliances, cracking and/or stretching of the corners of the mouth, cuts inside the mouth or on the lips, jaw fracture, stress or damage to the jaw joints (TMJ), difficulty in opening the mouth or chewing, allergic and/or adverse reaction to medications and/or materials;
    - Nerve injury, which may occur from the surgical procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, or altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste). Such conditions may resolve over time, but in some cases may be permanent;
    - Dry socket (slow healing) resulting in jaw pain that increases a few days after surgery;
    - Sharp ridges or bone splinters may form where the tooth was removed possibly requiring additional surgery;
    - Part of the tooth and/or roots may be left to prevent damage to nerves or other structures;
    - An opening may occur from the mouth into the nasal or sinus cavities;
    - Jaw fracture;
    - I understand that bone grafting may be necessary.

Patient's Initials _____

# TOOTH EXTRACTION INFORMED CONSENT

Patient's Name _____ Date of Birth _____

2. I have elected to proceed with the anesthesia(s) indicated below.

   _____ Local Anesthesia

   _____ Nitrous Oxide (Laughing Gas)

   _____ Mild Sedation

   _____ Moderate Sedation

   _____ Deep Sedation (General Anesthesia)

   I have been informed of and understand the potential risks associated with anesthesia include but are not limited to:

   - Allergic or adverse reactions to medications or materials;
   - Pain, swelling, redness, irritation, numbness and/or bruising in the area where the IV needle is placed. Usually the numbness or pain goes away, but in some cases, it may be permanent;
   - Nausea, vomiting, disorientation, confusion, lack of coordination, and occasionally prolonged drowsiness. Some patients may have an awareness of some or all events of the surgical procedure after it is over;
   - Heart and breathing complications that may lead to brain damage, stroke, heart attack (cardiac arrest) or death;
   - Sore throat or hoarseness if a breathing tube is used.

   If I have elected Mild, Moderate, or Deep Sedation (General Anesthesia), I have not had anything to eat or drink for at least six (6) hours prior to my procedure. I understand that doing otherwise may be life-threatening. As instructed, I have taken my regular medications (blood pressure medications, antibiotics, etc.) and/or any medicine given to me by my doctor using only small sips of water. I am accompanied by a responsible adult to drive me to and from the doctor's office and he/she will stay with me after the procedure until I am recovered sufficiently to care for myself. I understand the drugs given to me for this procedure may not wear off for 24 hours. During my recovery from anesthesia, I agree not to drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.

3. I have been informed of and understand that follow up visits or care, additional evaluation, treatment or surgery, and/or hospitalization may be needed.

4. Patient's Responsibilities

   I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

   I understand the use of tobacco and alcohol is detrimental to the success of my treatment.

# TOOTH EXTRACTION INFORMED CONSENT

Patient's Name _____ Date of Birth _____

I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications, risks, or less than optimal results.

I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

If I am sedated or under general anesthesia during the procedure, I further authorize the doctor to modify the procedure if, in his/her professional judgment, it is in my best interest.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature (optional) Date

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

_____ _____

Doctor Signature Date