**PATIENT INFORMATION**

Patient's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drivers License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a dental provider (i.e. general dentist, orthodontist, etc.)? ❑ no ❑ yes

If yes, please indicate provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is an immediate family member a patient here? ❑ no ❑ yes Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact you regarding upcoming appointments, reminders, or office specials via ❑ Email and/or ❑ Text Message

**Insurance Information:** ❑ Not covered by dental insurance

Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured ID or Social Security # \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dental Insurance Co\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy Information:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Zip \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_ \_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information:**

Name of nearest relative \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian *(if patient is a minor):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HEALTH HISTORY**

Do you have or have you had any of the following?

❑ no ❑ yes AIDS/HIV Postive

❑ no ❑ yes Allergies or Hives

❑ no ❑ yes Anemia

❑ no ❑ yes Angina Pectoris

❑ no ❑ yes Arthritis

❑ no ❑ yes Artifical Joint or Heart Valve

❑ no ❑ yes Asthma

❑ no ❑ yes Blood Tranfusion

❑ no ❑ yes Bruise Easily

❑ no ❑ yes Chemotherapy

❑ no ❑ yes Cold Sores/Fever Blisters

❑ no ❑ yes Congenital Heart Defects/Lesions

❑ no ❑ yes Cortisone Medicine

❑ no ❑ yes Cough

❑ no ❑ yes Diabetes

❑ no ❑ yes Emphysema

❑ no ❑ yes Epilepsy/Seizures

❑ no ❑ yes Fainting/Dizzy Spells

❑ no ❑ yes Glaucoma

❑ no ❑ yes Heart Attack/Disease

❑ no ❑ yes Heart Failure

❑ no ❑ yes Heart Murmur

❑ no ❑ yes Heart Surgery

❑ no ❑ yes Hepatitis A or B

❑ no ❑ yes High/Low Blood Pressure

❑ no ❑ yes Kidney Trouble

❑ no ❑ yes Liver Disease

❑ no ❑ yes Mitral Valve Prolapse

❑ no ❑ yes Pace Maker/Defibrillator

❑ no ❑ yes Psychiatric Treatment

❑ no ❑ yes Radiation Treatment

❑ no ❑ yes Rheumatism

❑ no ❑ yes Sleep Apnea

❑ no ❑ yes Sickle Cell Disease/Traits

❑ no ❑ yes Stroke

❑ no ❑ yes STD or VD

❑ no ❑ yes Thyroid Disease

❑ no ❑ yes Tuberculosis

❑ no ❑ yes Ulcers/Colitis

❑ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to, or have you reacted adversely to any of the following?

❑ no ❑ yes Latex materials

❑ no ❑ yes Penicillin or other antibiotics

❑ no ❑ yes Local anesthetics ("Novocain")

❑ no ❑ yes Codeine or other narcotics

❑ no ❑ yes Sulfa drugs

❑ no ❑ yes Barbiturates, sedatives, or sleeping pills

❑ no ❑ yes Aspirin

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any of the following?

❑ no ❑ yes Anticoagulants (blood thinners)

❑ no ❑ yes Antibiotics or sulfa drugs

❑ no ❑ yes High blood pressure medicine

❑ no ❑ yes Antidepressants or tranquilizers

❑ no ❑ yes Insulin, Orinase, or other diabetes drug

❑ no ❑ yes Nitroglycerin

❑ no ❑ yes Cortisone or other steroids

❑ no ❑ yes Osteoporosis (bone density) medicine

Please list **ALL** current medications you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you smoke, chew tobacco or vape? ❑ yes ❑ no

**\*This information is important for your safety during surgery.**

Use illicit drugs or have previously? ❑ yes ❑ no

**\*This information is important for your safety during surgery.**

**Primary Doctor**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women:**

❑ no ❑ yes May be pregnant

❑ no ❑ yes Taking hormones or contraceptive

Have you been hospitalized or had a serious operation or illness within the last five years? ❑ yes ❑ no

Do you have any disease, condition, or problem not listed above?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

**Consent:** *I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorugh diagnosis of the patient’s dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the Patient and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.*

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian *(if patient is a minor):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship To Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Receipt of HIPAA Notice of Privacy Practices**

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, filing insurance, and health care operations.

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 health care 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 at any time

**North Texas Dental Surgery**

**ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES**

**("Acknowledgement")**

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list person(s) we can release information to on your behalf:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature

-OR-

Signature of Personal Representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Policies**

**Insurance Policy:**

NTDS is in-network with all major PPO insurance companies, **EXCEPT** United Concordia.

Upon verifying your benefits, we will provide an estimate prior to your treatment. Please note, it is not guaranteed that your insurance will cover the treatment as estimated.

In the event you have limited coverage, you will be responsible for any charges and/or fees billed to your insurance company where payment is denied.

**Medical Denials:**

* Medical insurance will cover some oral surgeries, as some medical conditions may entitle you to dental coverage under your health insurance.
* Some dental insurance policies require that you bill the medical insurance company first, and once that claim is processed you can file a claim toward dental insurance.**This is when a Medical Denial is required.**
* **To ensure your treatment can be done in a timely manner, we will collect for any procedure that requires medical denial up front.**
* **Upon request, we will provide the medical claim form for you to submit to your medical insurance carrier. Once you submit the medical claim form, the explanation of benefits (EOB) will be mailed to you. When you have received your EOB, send us a copy, and we will submit it to your dental insurance carrier on your behalf.**
* **Patient initial: \_\_\_\_\_\_\_\_\_**

**Primary and Secondary Insurance:**

* **NTDS will verify both primary and secondary insurance.**
* **Your primary insurance will apply at the time of treatment. We cannot show estimated coverage with your secondary insurance until we bill the primary insurance.**
* **NTDS will bill your primary insurance for treatment.**
* **Once we receive the EOB back from your primary, we will bill your secondary. Secondary insurance requires an EOB from the primary insurance before a claim can be sent.**
* **Patient initial: \_\_\_\_\_\_\_\_\_**

**Predeterminations:**

* **A predetermination (pre-d) of benefits is a review by your insurer’s dental staff, to determine if they agree with your treatment that we have recommended for your dental needs.**
* **Predeterminations are done prior to your treatment, to ensure you understand what is covered vs what is not covered by your dental insurance plan.**
* **Patient initial: \_\_ \_\_\_\_\_\_**

**Payment Policy:**

For your convenience, NTDS accepts that following forms of payment:

* Debit cards
* All major credit cards (Visa, Master Card, and American Express)
* Care Credit
* Greensky
* Check
  + **Please note, NTDS must receive all checks AT LEAST 5 business days prior to your surgery. NTDS requires the FULL amount to clear the bank prior to the date of your surgery.**
* Patient Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Deposit Policy:**

NTDS will collect the following deposits upon scheduling your surgery. Please note, all deposits will go towards your total treatment amount.

* All on 4:
  + Day of scheduling impressions:
    - One arch: $6,200
    - Two arches: $12,400
  + Day of scheduling surgery: balance is due in full
* All other surgeries: **Remaining balances for the below surgeries are due in full the day of surgery.**
  + Implants: $200
  + Wisdom teeth: $200
  + Frenectomy: $200
  + Gingivectomy: $200
  + SRP (deep cleaning): $200
  + Expose & Bond: $200
  + Uncover: $200
  + Incision & Drainage: $200
  + Crown Seat: $200
  + Impressions: $200
  + Tissue Graft: $300
  + Osseous: $300
  + LANAP: $300
* Friday surgeries will require the balance due in full at the time of scheduling.
* Patient initial: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Rescheduling Policy:**

* All on 4:
  + All on 4 surgeries must be rescheduled **AT LEAST 7 calendar days in advance.**
  + Rescheduling an All on 4 surgery less than 7 calendar days in advance, is subject to the following nonrefundable office fees.
    - 7 calendar days or less = $500 for arch or $1000 for two arches
* All other surgeries:
  + Surgeries scheduled Monday – Thursday must be rescheduled **AT LEAST 3 calendar days in advance.**
* Rescheduling a Monday -Thursday surgery (i.e. wisdom teeth, implants, extractions, etc.) less than 3 calendar days in advance, is subject to the following nonrefundable office fees.
  + Rescheduling one time =$100
  + Rescheduling two times = $200
  + Rescheduling three times = NTDS will no longer accept you as patient
* Surgeries scheduled on Fridays must be rescheduled AT LEAST 7 calendar days in advance.
* Rescheduling a Friday surgery (i.e. wisdom teeth, implants, extractions, etc.) less than 7 calendar days in advance, is subject to the following office fees.
  + 7 calendar days or less = $200 nonrefundable office fee
* Patient initial: \_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read, understand, and agree to NTDS’s Insurance Policy, Payment Policy, Deposit Policy, and Rescheduling Policy. I understand failure to abide by these office policies could result in cancelation of my treatment and procedure.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Date: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (minor patients): \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID-19 Pandemic Dental Treatment Consent Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I have been made aware of the Center for Disease Control guidelines, the recommendations of the Texas Dental Association, American Dental Association, and Local/State Public Health Mandates that non-urgent dental care is not recommended. I understand that some dental infections, if left untreated, can lead to serious complications, including the need for hospitalization.

\_\_\_\_\_\_\_\_\_ I confirm I am seeking treatment.

Procedure Issues:

\_\_\_\_\_\_\_\_\_\_ I understand that the treatment provided by my dentist is elective. There may be a need for additional procedures to return the state of my mouth to optimum health. Failure to seek additional treatment that my doctor recommends may result in further issues, including pain, infection, and loss of teeth/bone and/or function.

\_\_\_\_\_\_\_\_\_\_ Due to the extreme nature of this pandemic, I understand that post-operative monitoring is difficult, in-office visits are may needed if complications arise.

\_\_\_\_\_\_\_\_\_\_ After my procedure, I understand that I may be at higher risk for further infection and agree to be to take precaution. I will alert North Texas Dental Surgery of anything out of the ordinary.

\_\_\_\_\_\_\_\_\_\_ I understand that to mitigate these risks, it is imperative that I take the medications as prescribed. I further understand that certain medications, such as opioid “pain” medications, cannot be called into pharmacies.

Unique Circumstances:

\_\_\_\_\_\_\_\_\_\_Dental procedures create water spray (aerosol), which is how the disease is spread. The ultrafine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

\_\_\_\_\_\_\_\_\_\_\_I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing.

\_\_\_\_\_\_\_\_\_\_\_ I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus by being in a dental office.

\_\_\_\_\_\_\_\_\_ I confirm that I do not have any of the following symptoms of COVOID-19: fever, shortness of breath, dry cough, runny nose, sore throat currently, or for the last 14 days.

\_\_\_\_\_\_\_\_\_\_ To my knowledge, I confirm that I have not been in contact with a person that has been diagnosed with COVID19 within the last 14 days.

\_\_\_\_\_\_\_\_\_\_\_ I understand that the CDC recommends social distancing of at least 6 feet to prevent transmission of disease and this is not possible with dentistry.

\_\_\_\_\_\_\_\_\_\_\_ I agree that, if I were to exhibit any symptoms of, or am diagnosed with, COVID-19, I will immediately contact North Texas Dental Surgery so that proper steps can be taken to limit the spread of this contagion.

\_\_\_\_\_\_\_\_\_\_I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be completely successful in resolving my pain and/or infection. It is anticipated that the treatment will provide benefit in reducing the cause of this condition. However, due to individual patient differences and the extenuating circumstances, there exists a risk of failure relapse, selective retreatment, or worsening of my present condition, including the loss of additional teeth/bone, despite the best care.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read, comprehend, and agree with the above statements. I consent to move forward with my dental surgery.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_