Dental/Medical History Questionnaire

Patient Name (printed): _____ DOB: _____ Date: _____

Chief Complaint/ Why are you here? _____

_____

HPI	Yes	No
1. Have you received medical treatment in the past 2 years?		
2. Do you have any reason to believe you have been exposed to or have HIV or AIDS?		
3. Have you ever had a sexually transmitted disease?		
4. Have you ever had any mental or nervous problems?		
5. If yes, are you receiving any treatment?		

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

	Yes	No		Yes	No	FEMALES ONLY:	Yes	No
1. Diabetes			1. Thyroid Problems					
2. Hepatitis/Jaundice?			2. Epilepsy/Seizures			1. Are you Pregnant?		
3. Heart Murmur			2. Arthritis/Rheumatism			2. Taking Birth Control?		
4. Rheumatic Fever			3. Blood Transfusions			3. Are you Breast Feeding?		
5. Heart Attack			4. Kidney Problems					
6. High Blood Pressure			5. Injury to Face or Neck					
7. Heart Valve/Pacemaker			6. Eye or Ear Problems					
8. Artificial Joint			7. Asthma					
9. Chemotherapy /Radiation			8. Sinus Problems					
10. Cancer or Tumors			9. Ulcers					
11. Stroke			10. TB or Lung Disease					

- Are you currently taking blood thinner medication? .....☐ Yes ☐ No
- Do you now have or have you had any disease, condition or problem not listed?.....☐ Yes ☐ No
  If Yes, explain:_____
- Do you have any concerns about receiving dental treatment?..... ☐ Yes ☐ No
- Are you allergic to or made sick by any medicine? (i.e. Penicillin, Aspirin, Codeine, etc)?....☐ Yes ☐ No
- Have you ever been hospitalized or had surgery?..... ☐ Yes ☐ No
- Do you smoke or use smokeless tobacco?.....☐ Yes ☐ No

Review of Systems	Yes	No
1. Do you have chest pain?		
2. Do you have a history of chest pain?		
3. Have you ever had a bleeding problem that required medical attention?		
4. Have you ever been exposed to HIV or AIDS?		
5. Have you ever had any problems with local anesthetics (novocaine)?		
6. Do you have problems chewing?		
7. Do you have problems swallowing?		
8. Have you experienced weight loss in the past 3 months?		

Patient/Parent/Guardian Signature _____ Date _____

EL CENTRO FAMILY HEALTH

Patient Information Form (Please Print)

Today's Date_____ eCW Account #_____PCP_____

Patient Demographic Information:

Last Name:_____First Name: _____ MI: _____

Physical Address:_____City:_____State:_____Zip Code:_____

Mailing Address:_____City:_____State:_____Zip Code:_____

Home Phone:_____-_____-_____ Work Phone:_____-_____-_____Ext. _____

Cell Phone:_____-_____-_____ Email Address:_____@_____

Date of Birth:____/____/_____

Emergency Contact:_____Phone:_____

Relationship:_____

Marital Status: □ Married □ Divorced □ Partner □ Single □ Widow □ Legally Separated

Sexual Orientation: □ Lesbian or Gay □ Straight (not lesbian or gay) □ Bisexual □ Something else:_____
□ Don't' know □ Choose Not to Disclose (Please Describe)

Birth Sex: □ Male □ Female □ Unknown

Gender Identity: □ Male □ Female □ Transgender Male/ Female-to-Male

□ Transgender Female/ Male-to-Female □ Other □ Choose Not to Disclose

Social Security #:_____-_____-_____

Employment Status: 1= Employee Full Time 2= Employed Part Time 3= Not Employed 4= Self Employed

(Please circle one) 5= Retired 6= On Active Military Duty

Student Status: F= Full Time P= Part Time N= Non Student

Responsible Party Information:

□ Self □ Guarantor (is guarantor an ECFH pt?) □ Yes □ No

(Please complete Responsible Party's Information below)

Last Name:_____First Name:_____Date of Birth: _____

Address:_____City:_____State:_____Zip Code:_____

Home Phone:_____-_____-_____ Work Phone:_____-_____-_____Ext. _____

Advance Directives: ie; POA, Living Will, Life Sustaining Will, Advance Directive

Do you have Advance Directives? □ Yes □ No Advance Directives on file □ Yes □ No

Do you have a Legal Guardian/Primary Care Giver? □Yes □ No □ Self

Name of Legal Guardian/Care Giver _____

Insurance Information:

Insurance Name:_____Telephone Number_____-_____-_____

Insured's Name:_____Subscriber ID #: _____

Group Number:_____Relationship to Patient: _____

Additional Information:

Please select appropriate "Race" box below:

□ American Indian/Alaskan Native □ White

□ Asian □ More than One Race

□ Native Hawaiian □ Other Pacific Islander

□ Black African/American □ Unreported/Refused to Report

Please select appropriate "Ethnicity" box below:

□ Hispanic or Latino □ Not Hispanic or Latino □ Refused to Report

Please select appropriate "Language" box below:

□ English □ Spanish □ Other (please specify)_____Limited English Proficiency □ Yes □ No

---

Are you a:

School Base Student □ Yes □ No

Veteran □ Yes □ No

Seasonal Worker □ Yes □ No

Migrant Worker □ Yes □ No

If you are prescribed medication today, which pharmacy would we send the prescription to:

Pharmacy Name:_____Location: _____

Income Verification Information:

Total Annual Household Income: □ $0.00-$20,000 □ $20,001- $40,000 □ $40,001-$60,000 □ $60,001-$80,000 □$80,001 - $100,000 □ More than $100,000

Number of Dependents:_____

I certify the above information is correct.

Patient's Printed Name: _____

Signature of Patient:_____ Date: _____

Signature of Legal Guardian:_____Date:_____

EL CENTRO FAMILY HEALTH

El Centro Family Health
PO BOX 158 Española, NM 87532
Web Site: *www.ecfh.org*

Authorization to Patient Records and Care

All Individuals Listed Must Have a DL/ID/Last Four Of S.S # to Validate.

Patient Information:

Name:________________________DOB:__________Pt's Last 4 of SS#__________

Enter a Security Code for pt's that do not have a Social Security #____________________

Address: ____

Telephone Number:______________

Signature:________________________Date:______________

- Name (First, Middle Initial, Last Name):____________________

Relationship to Patient:______________________________

Emergency Contact, Power Of Attorney, Parent/Legal Guardianship, Caregiver,

Address (City, State, Zip):______________________________

Telephone Number:______________________________

Telephone Number 2:______________________________

- ☐ To Have Access To Medical Records
- ☐ Ability to Make/Cancel/Reschedule Appointments.
- ☐ Other (Specify)______________________________

- Name (First, Middle Initial, Last Name):____________________

Relationship to Patient:______________________________

Emergency Contact, Power Of Attorney, Parent/Legal Guardianship, Caregiver,

Address (City, State, Zip):______________________________

Telephone Number:______________________________

Telephone Number 2:______________________________

- ☐ To Have Access To Medical Records
- ☐ Ability to Make/Cancel/Reschedule Appointments.
- ☐ Other (Specify)______________________________

- Name (First, Middle Initial, Last Name):____________________

Relationship to Patient:______________________________

Emergency Contact, Power Of Attorney, Parent/Legal Guardianship, Caregiver,

Address (City, State, Zip):______________________________

Telephone Number:______________________________

Telephone Number 2:______________________________

- ☐ To Have Access To Medical Records
- ☐ Ability to Make/Cancel/Reschedule Appointments.
- ☐ Other (Specify)______________________________

(This Form Is Good for One Year From the date signed.)

EL CENTRO FAMILY HEALTH

PO BOX 158
ESPAÑOLA, NM 87532
Web Site: *www.ecfh.org*

Patient Intake Re: Housing Situation: All patients
Please help us by filling out the following information regarding your housing situation:

Date:_____
Patient Name:_____ Date of Birth:_____
Patient phone number:_____ECFH will add account #:_____

Present Housing situation:

Please select appropriate category below:

_____Own home (owner or rental)

_____Transitional housing (temporary housing)

_____Doubling up with friends or relatives; staying with a series of relatives or friends

_____Shelter

_____Street: outdoors, in vehicle, abandoned buildings, makeshift housing

_____Other: single room occupancy hotel, motel, other day to day housing or other unstable housing situation

_____Without stable housing due to release from hospital, detox or jail: **please also mark another category** where you plan to spend the night tonight

In the past twelve months did you live in any of these situations?

_____Transitional housing (temporary housing)

_____Doubling up with friends or relatives; staying with a series of relatives or friends

_____Shelter

_____Street: outdoors, in vehicle, abandoned buildings, makeshift housing

_____Other: single room occupancy hotel, motel, other day to day housing or other unstable housing situation

Thank you for helping us to serve our patients.

El Centro Family Health
Medical/Behavioral Health/Dental
CONSENT FOR TREATMENT

The following information is to be completed by the patient/client or the patient's/client's parent or legal authorized representative.

I consent to medical/behavioral health/ dental treatment by the providers and clinical staff of El Centro Family Health for myself or for the patient for whom I am the parent or legal authorized representative. I authorize El Centro Family Health medical providers/ behavioral health /dental providers and other clinic personnel, to administer such medications and to carry out examinations and diagnostic procedures that may be deemed necessary and/or advisable for my health care/ behavioral health care/ dental health care during my enrollment with El Centro Family Health. The services/procedures mentioned beforehand may be performed at times by health professionals-in-training under supervision of responsible health professionals employed by El Centro Family Health. Administration of local anesthesia has possible risks associated with its use that although uncommon or rare, could include pain, swelling, bruising, infection, nerve damage, allergic reactions, which could result in heart attack, stroke, brain damage and or death. I voluntarily request and give permission for these services. I have read and understand what I am consenting to and I also understand that there are no guarantees resulting from these services.

AUTHORIZATION TO RELEASE TO INSURANCE

I, authorize El Centro Family Health to release medical, behavioral health, dental or other information to third party payers, the third party payer's agent and/or representative, which may be necessary for the completion of insurance claims, review of services, or receipt of benefits.

AUTHORIZATION FOR PROVIDER TO ACCESS EXTERNAL PRESCRIPTION HISTORY

I authorize El Centro Family Health to retrieve prescription history from an external source(s) utilizing eClinical Works electronic medical software.

AUTHORIZATION TO RELEASE TO CONSULTING PROVIDER

I authorize El Centro Family Health to release medical information or behavioral health information, or dental health information as deemed necessary by my ECFH medical provider, behavioral health provider, or dental health provider to consulting providers in order to provide continuity of my medical, behavioral health or dental care.

I consent to have my photo taken to help avoid any fraud or medical identity theft. YES or NO

Signature of patient, client, parent or
Legally authorized representative:_____Date: _____

Patient Portal – Consent Form

Purpose of this Form:

El Centro Family Health offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:
1) The secure message must reach the correct personal email address, and
2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.** You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Portal – Consent Form

Types of Online Communication/Messaging:

Online communications should never be used for emergency communications or urgent requests. If you have an emergency please call 911 or go to your nearest emergency facility. For an urgent request you should contact your physician via telephone. For afterhours medical questions or medical assistance please contact the Call 4 Health at 1-505-715-4327 and identify yourself as an El Centro Family Health Patient.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the disclaimer and terms of use regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the disclaimer and terms of use set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand by agreeing to this I certify I am over the age of 18. I understand and agree with the information that I have been provided.

Print Patient Name:_____ Date of Birth:_____

Email Address:_____

_____ _____
Signature Date

I am over the age of 18 and have sole responsibility of my medical care.
(We do not offer the Patient Portal to minors or those patients who do not make their own medical decisions at this time. We apologize for the inconvenience.)

☐ Yes
☐ No

I choose not to participate in Patient Portal at this time because:

☐ I do not have an Email Address
☐ I do not wish to share my Email Address
☐ Other

EL CENTRO FAMILY HEALTH

PO BOX 158
ESPAÑOLA, NM 87532
Phone: 505-753-7218
Fax: 505-753-5815
Web Site: www.ecfh.org

Patient: _____
(Please print)

Date of Service: _____

Patient Statement of Financial Responsibility

○ I understand and agree that my nominal fee, co-payment, co-insurance and/or deductibles are due and payable at the time of service, and I may receive a bill for any amounts due that are not collected at time of service.

○ I understand that services not covered through my benefits, as well as any applicable co-payments and deductibles are my responsibility.

○ I understand that an inactive insurance card, no insurance, no insurance card, or insurance we are not a participating provider for will render me responsible for payment for services.

The insured/Guardian/Patient is advised that all labs, prescriptions and/or other services are due and payable at time of service.

The Insured/Guardian/Patient is advised that a copy of the patient's insurance card is required to submit a claim.

The Insured/Guardian/Patient is advised that this document will become a part of the patient's medical record and billing statements will be sent for services should any of the above occur.

The Insured/Guardian/Patient is also advised that most carriers have a claims filing limit. Correct insurance information received greater than 60 days from the date of this document may be denied by their carrier as untimely and the insured/guardian/patient will be held responsible for any balance.

Guardian/Insured/Patient:_____
(Signature)

Date:_____ Staff Initials: _____

El Centro Family Health
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMRAIOTN. PLEASE REVIEW IT CAREFULLY.

Dear Patient:

A federal law has created new rights for customers of healthcare organizations. The law is called the Health Insurance Portability and Accountability Act of 1996. The law requires us to give you this Notice of Privacy Practices, which tells you about your rights and explains how we protect the privacy of your health information.

You may read this Notice now or at another time. This Notice explains the ways that we use and share health information about you, and when your health information may be used and shared without your permission.

Also, this Notice explains your health information rights, including:

- Your right to receive this Notice;
- Your right to ask us to limit or restrict our use or sharing for you health information;
- Your right to see and get a copy of most health information in our records (if you think the information is not correct); and
- Your right to file a complaint if you think your privacy rights have been violated.

At El Centro Family Health, we are serious about protecting your privacy. If you have any questions about this Notice or would like more information about our privacy practices, please call or visit with our local Clinic Manager.

I certify that I have received a copy of the El Centro Family Health Notice of Privacy Practices.

_____ _____

Patient Signature Date

Telehealth Consent

I, _____ (client name), agree to participate in telehealth with a provider (medical and/or behavioral health provider) at El Centro Family Health (ECFH).
This means that:

- I authorize information about my medical and mental health care to be transferred electronically through an interactive video and/or audio connection (e.g., Zoom, Doximity or standard telephone lines).
- My provider has explained how the telehealth system works and how it will be used for my treatment.
- My provider has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.
- I understand that any changes to my demographics to include phone number or address must be communicated with ECFH.
- I understand that my provider will not be physically present during my telehealth appointment. Instead, we will communicate through electronic means.
- I understand that telehealth is an evolving modality for medical and therapy appointments. As such, there may be potential risks that may not yet be recognized.
- I understand that if connection is lost, my provider will attempt to reconnect.
- I understand that in the event connection is lost between myself and my provider during a crisis or emergency, I am to seek care at my local hospital emergency room or call 911.
- Potential risks to telehealth include a) at times the audio and/or video image may be unclear or inadequate, b) a disruption in the connection may occur, or c) in rare circumstances, the information may be intercepted by unauthorized persons.
- I understand that the provider may be limited in that they are unable to consider the visual or non-verbal cues of the patient.
- I understand that at any time, I may decide to discontinue telehealth appointments or sessions with my provider. If possible, my provider will refer me to a provider who can provide face-to-face services.
- I agree to take every precaution to preserve the confidentiality of my sessions, such as ensuring that calls are taken in a safe and secure location to the extent possible. I understand that I or my provider may determine the conditions that will make the telehealth appointment inappropriate to continue and another appointment will be rescheduled.
- My provider has explained the risks and benefits of receiving telehealth. I understand that I still may need to see a specialist in-person.
- I understand that information from my telehealth sessions will be protected by HIPPA privacy laws. I may request a copy of my electronic record in writing.
- I understand that audio and video recordings are not allowed during telehealth sessions.

I voluntarily consent to participate in telehealth services using telehealth equipment for the care, treatment, and services deemed necessary and advisable under the terms set forth herein.

Client DOB: _____ Client Chart #: _____

_____ _____
Client Printed Name Date

_____
Client Signature

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Witness Signature Date

EL CENTRO FAMILY HEALTH

Accredited by
Accreditation Association
for Ambulatory Health Care, Inc.

YOUR RIGHTS AS A MEDICAL HOME PATIENT

El Centro Family Health is committed to protecting and ensuring your rights as a patient.

You have the right:

1. To efficient and equal services, regardless of your race, sex, religion, ethnic background, education, social class, physical or mental handicap, or economic status.
2. To considerate courteous and respectful care from all staff in our facilities.
3. To complete information shared with you in a manner you can understand.
4. To full discussion of risks, benefits and alternatives to invasive procedures, prior to procedures, except in an emergency.
5. To obtain assistance in interpretation for non-English speaking patients.
6. To know the names, titles and professions of any facility staff who cares for you during your visit.
7. To refuse examination, discussion and procedures to the extent permitted by law, and to be informed of the health and legal consequences of this refusal.
8. To access your personal health records.
9. A patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
10. A patient has the right to privacy with respect to his or her medical condition. A patient's care and treatment will be discussed only with those who need to know.
11. To confidentiality of your personal health records as provided by law.
12. To expect reasonable continuity of care within the scope of services and staffing of this facility.
13. To respect for your civil rights and religious opinions.
14. To present complaints to the management of this facility without fear of reprisal.
15. To examine and receive a full explanation of any charges made by this facility, regardless of the source of payment.
16. You have the right to make an advance directive and appoint someone to make health care decisions for you if you are unable. If you do not have an advance directive, we can provide you with information and help you complete one.
17. You have the right to voice your complaint/grievance expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare/Medicaid or Private Insurance Health Plan, or its providers, regardless of whether remedial action is requested.

If you have any concerns, complaints or grievance, you may talk with your doctor, nurse manager, clinic manager, or regional administrator at your clinic. You may also contact the Chief of Operations at 505-753-7218.

If your complaint/grievance is not resolved to your satisfaction, you may also contact:
Centers for Medicare & Medicaid Services (CMS) - 1-877-787-8999

Medicare Ombudsman www.medicare.gov or call 1-800 633-4227

New Mexico Department of Health - 1-800-445-6242 (Toll Free)

PATIENT RESPONSIBILITIES AS A MEDICAL HOME PATIENT:

1. To participate to the best of your ability in making decisions about your medical treatment, and to comply with the agreed upon plan of care.
2. To ask questions of your physician or other care providers when you do not understand any information or instructions.
3. To inform your physician and other care providers if you anticipate problems in following prescribed treatment.
4. To inform your physician or other care provider if you desire a transfer of care to another physician.
5. Not give medications prescribed for you to others.
6. Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information and to report any changes in their medical status to their care provider.
7. Respect the rights of other patients, families, visitors and staff. Refrain from the use of inappropriate language or actions related to race, creed, color, national origin, ancestry, religion, gender, gender identify or expression, sexual orientation, marital status, age, disability or political affiliation.
8. Patients may not disrupt or interfere with their care provider, other patients, or the operations in patient care and office areas.
9. Patients have the responsibility to make and keep appointments, arrive on time, stay for the entire time scheduled, and provide a minimum of 24 hours' notice to change or cancel appointments.
10. Watch your children to prevent safety issues and avoid disturbing other patients and families.
11. Patients have the responsibility to follow the treatment plan to which they agreed, including any recommended follow-up instructions. Patients are responsible for the outcomes if they do not follow the care and treatment plan.
12. Patients have the responsibility to provide updated, accurate insurance and billing information (including name, mailing address, phone number, and any other requested information for billing purposes), and for meeting the financial obligation agreed to.
13. Patients may not conduct any illegal activities on any ECFH properties.

By signing this you agree that you have been given the opportunity to read your patient rights and responsibilities.

_____ _____

Patient Signature Date

El Centro Family Health Dental Department Appointment Policy

Because of the overwhelming demand for dental appointments at El Centro we have found it necessary to adopt the following policy regarding broken appointments. This is intended to assure that valuable appointments are used as effectively as possible.

Patients with three broken appointments within a twelve month period will be eligible for emergency care only for a period of 6 months after the third broken appointment. An appointment is considered broken if the patient (1) does not show up for the appointment, (2) arrives more than 15 minutes late, or (3) cancels the appointment with less than 24 hours notice.

After 6 months the patient may request reinstatement for routine care once again.

Patient:_____ Date:_____

Regamento de Citas Dentales

Debido a la demanda de citas dentales hemos implementado el siguinte reglamento. El propósito del reglamento es asegurar que las citas disponibles sean usadas efectivamente.

Si un paciente falla tres en un de 12 meses no va a poder hacer otra cita por 6 meses comenzando en la fecha de la tercera cita fallada. A menos que sea una Emergencia. Consideramos la cita fallada (1) si no viene a la cita, (2) si leggan mas de 15 minutos tarde, o (3) si llaman para cancélar la cita con menos de 24 horas de noticia.

Después de meses el paciente puede volver a hacer citas pare tratamiento de rutina otra ves.

Paciente:_____ Date:_____

El Centro Family Health COVID-19 Pandemic Dental Treatment Consent Form

The New Mexico Department of Health asks all individuals who have the following: cough, fever, shortness of breath, runny nose, or sore throat (that is not related to a pre-existing illness or health condition) to be in isolation (quarantine) for 14 days from the start of symptoms, or until symptoms resolve, whichever takes longer. If the individual (s) develop any respiratory symptoms such as cough, shortness of breath or fever, it is recommended they call 855-600-3453 and press option 2 for guidance. Testing sites for anyone in New Mexico can be found on the Department of Health website at *COVID-19 Test Sites*.

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____ (Initial)

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a dental office, as opposed to self isolation at home. _____ (Initial)

I confirm I know that there are categories of people who are considered to be high risk. I understand the high risk category factors are being 65 years of age or older, heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder. _____ (Initial)

I have discussed with El Centro Family Health Dental Department the pros and cons of my recommended dental treatment being performed in relation to contracting COVID-19.

Although there are no guarantees in regards to the possibility of contracting COVID-19, my dentist and his staff will be following safety protocols as to best protect myself and the staff during treatment. I am satisfied that my dentist answered all of my questions. I understand that I have the option to delay my treatment, and I have elected to have the procedure at this time.

Recommended Treatment

_____

_____

I knowingly and willingly consent to have the above listed dental treatment completed during the COVID-19 pandemic and I verify the information I have provided on this form is truthful and accurate.

_____

SIGNATURE OF PATIENT (Or Legal Guardian)

Printed Name of patient: _____ Date_____