New Bite
DENTISTRY & ORTHODONTICS

# COVID-19 Assessment Form

**Patient Information**

First Name: _____ Last Name: _____ Sex M/F

Address: _____ City: _____ State:_____ Zip: _____

Phone: _____ Age: _____

Have you or a family member in your household traveled outside of the US? Y/N

If yes, please indicate the date of travel and the location.

---

Have you or a family member in your household been to an Emergency room or hospital? Y/N

If yes, please indicate the date _____

Have you or a family member in your household been to a large gathering of over 50 people recently? Y/N

If yes, please indicate the date of the gathering and the location.

---

**Symptoms**

Do you have, or have you had, any of the following? (Please circle all that apply to you)

| | | |
|---|---|---|
| Fever | Headaches | Vomiting |
| Cough | Sore Throat | Pneumonia |
| Shortness of breath | Abdominal Pain | ARDS |
| Chills | Diarrhea | Muscle Aches |

If you indicated yes to any of the above symptoms, we would have to postpone your treatment until further notice to protect patient's and staff from the rapid spread of COVID-19. We appreciate your cooperation and understanding.

Patient, Parent, Guardian Print name: X_____
Patient, Parent, Guardian Signature: X _____ Date: _____

New Bite
DENTISTRY & ORTHODONTICS

## Office Policy and Consent

**Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.**

### Insurance and Payment Policy

**FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.

**For patients with Dental Insurance**:

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment. Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

### Office Policies

Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 48-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $80.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $80 cancellation fee will be assessed for the first individual and $50 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**

Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.

We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.

We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.

Treatment appointments made that **exceed $500.00 will require 10% down** to hold the appointed time.

### Consent

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Patient, Parent, Guardian Signature: X_____

Patient, Parent, Guardian Print name: X _____ Date: _____

New Bite
DENTISTRY & ORTHODONTICS

## Medical History

Patient Name: _____ Birth Date: _____

**Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.**

Are you under a physician's care now? ___Yes ___ No If yes, please explain: _____
Physician's name: _____ Physician's Phone number: _____ Last Exam: _____
Have you ever been hospitalized or had a major operation? ___Yes ___ No If yes, please explain:
_____
Have you ever had a serious head or neck injury? ___Yes ___ No If yes, please explain: _____
Are you taking any medications, pills or drugs? ___Yes ___ No If yes, please explain:
_____
_____
Are you taking Coumadin, Warfarin, Aspirin or any blood thinners? ___Yes ___ No If yes, please explain:
_____
Do you use tobacco? ___Yes ___ No If yes, please explain: _____
Do you use controlled substances? ___Yes ___ No If yes, please explain: _____
Women, are you? Pregnant/ trying to get pregnant? __ Y ___ N Taking Oral Contraceptives? __ Y ___ N
Nursing __ Y ___ N
Are you allergic to any of the following? ___Aspirin ___Penicillin ___Codeine ___Local Anesthetics ___Acrylic ___Metal ___Latex ___Sulfa drugs ___ Other _____ If yes, please explain the reaction:_____
Do you have, or have you had, any of the following? (Please circle all that apply to you)

| | | | |
|---|---|---|---|
| AIDs/HIV Positive | Congenital Heart | Trouble/disease | Renal dialysis |
| Alzheimer's disease | Disorder | Hepatitis A | Rheumatic fever |
| Anemia | Emphysema | Hepatitis B or C | Sickle Cell disease |
| Angina Arthritis | Epilepsy or Seizures | Herpes | Sinus Trouble |
| Artificial heart valve | Excessive bleeding | High blood pressure | Stroke |
| Artificial Joints | Fainting | High Cholesterol | Thyroid disease |
| Asthma | Dizziness | Kidney problems | Tuberculosis |
| Blood Disease | Headaches | Leukemia | Ulcers |
| Breathing Problem | Glaucoma | Liver disease | Venereal disease |
| Cancer | Hay Fever | Low blood pressure | Yellow Jaundice |
| Chemotherapy | Heart Attack/Failure | Osteoporosis | Diabetes |
| Chest pains | Heart Murmur | Pain in jaw joints | |
| Cold Sores/Fever blisters | Heart Pacemaker | Radiation | |
| | Heart | | |

__ Have you ever had any serious illness not listed above? Comments:
_____ To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Patient, Parent, Guardian Signature: X_____
Patient, Parent, Guardian Print name: X _____ Date: _____

New Bite
DENTISTRY & ORTHODONTICS

# Privacy Policy

**This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.**

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 972-245-2483.

## Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

## How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. New Bite Dentistry and Orthodontics does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment.

*Safeguarding Your Personal and Health Information*

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

New Bite Dentistry and Orthodontics maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with New Bite Dentistry and Orthodontics.

## Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. New Bite Dentistry and Orthodontics occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

## Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient, Parent, Guardian Signature: X_____

Patient, Parent, Guardian Print name: X _____ Date: _____

New Bite
DENTISTRY & ORTHODONTICS

**INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES**

You have the right to accept or reject dental treatment recommended by your dentist. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatments or the option of no treatment.

It is very important that you provide New Bite Dentistry & Orthodontics with an accurate medical history before, during and after treatment. It is equally important that you follow your Dr. Koo's and or associates advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of Dr. Koo's and or associates, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. Do not sign this form or agree to treatment until you have read, understood and accepted each item carefully. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.

During your course of treatment the following care may be provided to you:

· **EXAMINATIONS AND X-RAYS** Radiographs are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnosis any x-rays taken. In the state of Texas a dental hygienist ***cannot*** diagnosis a patient.

· **DENTAL PROPHYLAXIS (CLEANING)** A routine dental prophylaxis involves the removal of plaque and calculus ***above the gum line*** and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature the office should be contacted.

· **PERIODONTAL TREATMENT** Periodontal disease is an infection causing gum inflammation and/or bone loss that can lead to tooth loss. At times when a routine cleaning is schedule the dental hygienist and dentist may discover periodontal disease is present in all or certain areas of your mouth. If you present with an infection during your routine cleaning appointment it may be necessary for more extensive treatment to be performed. The dental hygienist will stop the routine cleaning and explain to you alternative treatment plans including nonsurgical cleaning ***below the gum line***, placement of an antibiotic below the gum line or a gross debridement (two part cleaning). If further treatment such as gum surgery and/or extractions are necessary a comprehensive periodontal exam will be scheduled with our dentist. The success of any periodontal treatment depends in part on your efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow any other recommendations. Some bleeding after deep cleanings or scaling under the gum line can occur, however, should it persist and if it is severe in nature the office should be contacted. Untreated periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

**Changes in Treatment Plan**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

**Allergies/Medication**
I have informed New Bite Dentistry & Orthodontics of any known allergies I may have. I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs.
I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

**Consent**
I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure.

_____
Patient Name

_____ _____
Patient or Parent/ Legal Guardian Signature Date

New Bite
DENTISTRY & ORTHODONTICS

**Patient Information (Confidential)**

Name: _____Date of Birth: _____Age: _____
Address: _____City/State: _____Zip: _____
Social Security #: _____-_____-_____DL#: _____Home Phone: _____
Email:_____ Cell Phone:_____ Receive Text: YES/NO
Check Appropriate: Minor_____ Single_____ Married _____Divorced_____ Widowed_____
Patient or Parent/Guardian Employer:_____ Work Phone:_____
Business Address: _____City/State:_____ Zip:_____
Spouse or Parent/Guardian's Name:_____ Employer:_____
Person to contact in case of an emergency: _____ Phone: _____
Whom may we thank for referring you?_____

**Responsible Party**

___ Check if the patient is the same as the responsible party. Please skip the following box.
___ Check if the patient is different from the responsible party. Fill out this section.
Name of person responsible for this account: _____Relationship to patient: _____
Address:_____ Home Phone:_____
Email:_____ Driver's License:_____
Is this person currently a patient in our office? ___Yes ___ No
For your convenience, we offer the following methods of payment. Please check the option you prefer.
Payment in full at each appointment. ___ Cash ___ Personal Check ___Credit Card ___ I wish to discuss the office's payment policy

**Please fill out next book if you have insurance. If not applicable, please skip and proceed to next page. Thank you.**

**Insurance (if applicable)**

Primary: Name of Insured: _____Relationship to patient: _____
Birthdate: _____ SS#:_____-_____-_____ Name of Employer:_____
Employer Address:_____ City/State: _____ Zip Code:_____
Insurance Company Name:_____ Group #:_____ Policy ID:_____
Secondary: Name of Insured:_____ Relationship to patient:_____
Birthdate:_____ SS#: _____-_____-_____ Name of Employer:_____
Employer Address: _____ City/State: _____ Zip Code:_____
Insurance Company Name: _____ Group #: _____ Policy ID:_____

Patient, Parent, Guardian Signature: X_____
Patient, Parent, Guardian Print Name: X _____ Date: _____