Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Welcome!

We recognize you had a choice and thank you for choosing our dental healthcare team! Your information is confidential. To help us better assist you, please print and complete all spaces. Periodically you will be asked to update your information. This replaces all previous provided.

PATIENT INFORMATION (CONFIDENTIAL)

Date: _____ (Office Only) Patient # _____

Birth Date: _____/_____/_____ Social Security # _____/_____/_____
Month Day Year

Name: _____/_____/_____/
First Middle Last Suffix Male / Female

Address_____ City_____, GA Zip Code_____

Home Phone: ( )_____ Cell: ( ) _____Work: ( ) _____

Emergency Contact: _____ Phone: ( ) _____

E-mail Address: _____

Would you like to receive text messages in the future? Yes_____ No_____

Is anyone authorized to discuss this account other than the patient? Yes_____ No_____

If yes, whom_____ Relationship to Patient_____

How did you hear about us? _____

RESPONSIBLE PARTY

Name of Person responsible for this Account? _____

Is the responsible party a patient in our office? Yes_____ No_____

Name: _____ (i.e., Sr., Jr., II)
First Middle Initial Last Suffix

Address_____ City_____, GA Zip Code_____

Home Phone: ( )_____ Cell: ( ) _____Work: ( ) _____

Relationship to Patient: _____

PATIENT DENTAL HISTORY

Name of Previous Dentist: _____ Location of Previous Dentist: _____

Date of Last Cleaning: _____/_____ Date of Last Exam: _____/_____
Month / Year Month / Year

1. Do your gums bleed while brushing or flossing? ..... Y N
2. Are your teeth sensitive to hot and/or cold liquids/foods? ..... Y N
3. Are your teeth sensitive to sweet and/or sour liquids/foods? ..... Y N
4. Do you feel pain in your teeth? ..... Y N
5. Do you have any sores or lumps in or near your mouth? ..... Y N
6. Have you ever had any head, neck or jaw injuries? ..... Y N
7. Do you have frequent headaches? ..... Y N
8. Do you clench or grind your teeth? ..... Y N
9. Do you bite your lips or cheeks frequently? ..... Y N
10. Have you ever had any difficult extractions in the past? ..... Y N
11. Have you have had any prolonged bleeding following extractions? ..... Y N
12. Have you ever had orthodontic treatment? ..... Y N
13. Do you currently wear dentures or partials? If so, date of placement? ..... Y N
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ... Y N
15. Are you satisfied with your smile? ..... Y N
    If not, what would you like to improve? _____
16. Have you ever experienced any of the following in your jaw? ..... Y N
    - Clicking ..... Y N
    - Pain (joint, ear, side of face) ..... Y N
    - Difficulty opening or closing your mouth ..... Y N
    - Difficulty in chewing ..... Y N

PATIENT MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, the mouth is a part of the entire body. Health problems that you many have or medication that you may be taking could have an **important interrelationship with the dentistry you will receive. Providing incorrect and/or withholding important health information can be dangerous to the health of the patient**

Are you under a physician care now?	Y	N
Have you ever been hospitalized or had a major operation?	Y	N
Have you ever had a serious neck injury?	Y	N
Do you take or have you taken Phen-Fen or Redux?	Y	N
Are you on a special diet?	Y	N
Do you use tobacco?	Y	N
Do you use any controlled substance?	Y	N

WOMEN: Are you pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives ☐

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other – If yes, please explain:

_____

Please list all medications, herbal supplements, vitamins, you are taking _____

_____

Please circle any of the following you have, or have you had:

AIDS/HIV Positive	Chest Pains	Frequent Headaches	*Joint Replacement	Scarlet Fever
Alzheimer's	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Arthritis/Gout	Cortisone Medicine	Heart Attack/Failure	Low Blood Sugar	Spina Bifida
*Artificial Heart Valve	Diabetes	Heart Murmur	Lung Disease	STD Stomach/Intestinal
*Artificial Joint	Drug Addiction	*Heart Pace Maker	*Mitral Valve Prolapse	Stroke
Asthma	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joint	Swelling of Limbs
Blood Disease	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Transfusion	Epilepsy/Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Breathing Problem	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tuberculosis
Bruise Easily	Fainting Spells/Dizziness	Herpes	Renal Dialysis	Ulcers
Cancer	Frequent Cough	High Blood Pressure	*Rheumatic Fever	Venereal Disease
Chemotherapy	Frequent Diarrhea	Irregular Heartbeat	Rheumatism	Yellow Jaundice

Have you ever had any serious illness not listed above? No_____ Yes_____ Please explain: _____

Some conditions require pre-medication. Please consult your personal physician prior to treatment to see if this applies to you

CONSENT FOR TREATMENT

I hereby authorize Dr. M. Usman Sajid D.D.S and his designated staff to take x-rays, photographs, models and any other diagnostic aids considered appropriate by doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by myself and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks and that certain dental procedures can have inherent and potentials risks and that I can ask for a complete recital of any possible complications.

PRIVACY PRACTICES

We are required by law to maintain the privacy of your health information. You may request a copy of our notice at any time. This notice remains in effect until we replace it.

AUTHORIZATION and RELEASE

I hereby authorize release of any information, including diagnostic and records of treatment and examination rendered to my insurance company.

FINANCIAL POLICY

Payment is due in full at the time of treatment unless approved prior arrangements have been made. This office accepts approved insurance. I understand that I am responsible for payment of services rendered and all co-payments, deductibles and all other authorized charges incurred that my insurance does not cover. I understand insurance payments are estimates and additional costs may be due. In the event my insurance company does not pay my claim within 60 days, the entire balance remains my responsibility. Our office will make an attempt to remind you of your scheduled appointment. If you need to reschedule or cancel, we require 48-hour notice. Failure to notify our office will result in a $50.00 charge to you. A $35.00 fee will be charged for any dishonored check and we will no longer accept your checks.

For your convenience, we accept Cash, 

I have read and understand your policies. I believe the information I have provided today is true and correct to the best of my knowledge. I understand that providing incorrect and/or withholding important health information can be dangerous to my/patient's health. I also understand this information will be held in the strictest of confidence and it is my responsibility to inform this office of any change in my name, address, insurance, and/or medical status prior to treatment.

Signature of Patient (or parent/guardian if minor) _____

Print Name of Patient (or parent/guardian if minor) _____

Relationship: _____ Today's Date: _____

Email: LSFamDent@Gmail.com

01/2020

SWEET WATER FAMILY DENTISTRY

Dental Insurance Estimate Acknowledgement

Insurance estimates and patient portions are an estimate based on information provided by your insurance company. Insurance provides a basic, not detailed, overview of benefits and not a guarantee of payment. Treatment is not dependent or contingent on payment from insurance company. In the event that insurance denies all or part of the claim, the remaining balance will become the patient's responsibility. In order to provide the highest standard of care, we provide treatment in accordance to ADA guidelines. If these procedures are not covered by your insurance for any reason, the cost will become the patient's responsibility.

I have read and understand the above policy.

_____ _____

Signature of patient (Or parent/guardian if minor) Date

_____ _____

Treatment plan coordinator - Hygienist - Dental Assistant Date

SWEET WATER
FAMILY DENTISTRY

COVID-19 Pandemic Dental Treatment Consent Form

I, _____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

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 give the current limits in virus testing. Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can last in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- _____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of a least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. _____(Initial)

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. _____ (Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____(Initial)

Name_____ Date_____

SWEET WATER FAMILY DENTISTRY

Consent & Release Form: Photography, Video and/or Testimonials

I grant Sweet Water Family Dentistry and its affiliates, licensees, agents, successors, transferees, assigns (collectively "Company") the right, permission and license to use my testimonial and/or photos and/or video in all media (print, electronic or otherwise) and types of advertising, promotion and illustration that the Company deems to be appropriate. I hereby specifically grant the company a worldwide, irrevocable, perpetual right and license to use, reproduce, print, distribute, publish, broadcast and rebroadcast, as well as to copyright my photographic and video likeness and to use or not use my name in connection thereof. All right, title and interest to the photographic images and video footage, electronic, negatives and positives, together with the prints, as covered by this Consent and Release, including all copyrights therein, will be the sole property of the Company free from any claims whatsoever by me and I am not entitled to copies of such.

I understand that the testimonial and photographic images may be used for patient education, advertising and/or promotional purpose and that I will not have any right to compensation in the event that the use of my name or likeness is used by the Company for any lawful purpose. I hereby release the Company from any and all claims arising out of their use as agreed to herein, including without limitation any claims based on the right of publicity or privacy. I hereby waive any right to review any advertising or promotional materials and agree that no advertisement, promotion or other material need to be submitted to me for any approval.

Sweet Water Family Dentistry will not condition providing treatment to me on my execution of this authorization form. I have the right to revoke this authorization for future disclosures by completing the revocation section of the form below. Please be aware that any information that is disclosed to a third party pursuant to this authorization may be subject to redisclosure and no longer protected by Sweet Water Family Dentistry's policies and applicable law. If the authorization is revoked, Sweet Water Family Dentistry can only pull the testimonial and/or photos and/or video from its websites and cannot control uses and retractions by others once published on the internet.

I hereby authorized Sweet Water Family Dentistry to make the use or disclosure of my testimonial as set forth above.

_____ _____

Printed Name Date

_____ _____

Signature of Patient (or authorized guardian) If authorized guardian, Relationship to patient

_____ _____

Witness Signature Date

Revocation (to be completed by patient if patient subsequently wishes to revoke authorization)

I hereby revoke this authorization.

_____ _____

Printed Name Date

_____ _____

Signature of Patient (or authorized guardian) If authorized guardian, relationship to patient

Acknowledgement of Receipt of Notice of Privacy Practices

Sweet Water Family Dentistry, P.C.

You May Refuse to Sign This Acknowledgment

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

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgment 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)

_____

_____