COVID-19 PATIENT SCREENING

Name: ____________ Date of Birth: _____

Do you have a fever or have you felt hot or feverish recently (14-21 days)?

☐ Yes ☐ No

Are you having shortness of breath or other difficulties breathing?

☐ Yes ☐ No

Do you have a cough?

☐ Yes ☐ No

Do you have any flu-like symptoms, such as gastrointestinal upset, headache or fatigue?

☐ Yes ☐ No

Have you experienced recent loss of taste or smell?

☐ Yes ☐ No

Have you had any contact with any confirmed COVID-19 positive patients?

☐ Yes ☐ No

Is your age over 60?

☐ Yes ☐ No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?

☐ Yes ☐ No

Have you traveled in the past 14 days to any regions affected by COVID-19?

☐ Yes ☐ No

Signature: ________________________ Date: _____________

Name: ______________________ Date of Birth: ___________

Demographics

First name: ____

Last name: ____

Sex: ____

Birth date: ____

Email address: ______________________________________

Phone number: ______________________________________

Address line 1: ______________________________________

Address line 2: ______________________________________

City: ____

State: ____

Postal code: ____

Signature: _______________________ Date: _____________

Name: ______________________ Date of Birth: ___________

Dental History

Reason for visit____

Date of last dental visit____

Date of last dental X-rays____

How often do you floss____

How often do you brush____

Bad Breath____

Bleeding, Red, Swollen Gums____

Broken/Loose teeth or fillings____

Clicking or popping jaw____

Grinding teeth____

Pain around ear/side of face____

Sores/Blisters in mouth____

List any other dental concerns/pain____

Signature: _______________________ Date: _____________

Name: ______________________ Date of Birth: ___________

Dental Insurance

Name of insured____

Insured's birth date____

Insured's address line 1____

Insured's address line 2____

Insured's city____

Insured's state____

Insured's postal code____

Patient's relationship to insured______________________________________

Insured's employer name____

Employer's address line 1____

Employer's address line 2____

Employer's city____

Employer's state____

Employer's postal code____

Plan name____

ID #____

Group #____

Insurance company phone number__________________________________

Insurance's address line 1____

Insurance's address line 2____

Insurance's city____

Insurance's state____

Insurance's postal code____

Signature: ________________________ Date: _____________

Name: ______________________ Date of Birth: ___________

Medical History

Allergy : YES / NO
Aspirin : YES / NO
Allergy : YES / NO
Codeine : YES / NO
Allergy : YES / NO
Latex : YES / NO
Allergy : YES / NO
Local Anesthetic : YES / NO
Allergy : YES / NO
Penicillin : YES / NO
Allergy : YES / NO
Sulfa : YES / NO
List any other allergies: : YES / NO
Abnormal (High/Low) Blood Pressure : YES / NO

AIDS/HIV : YES / NO

Anemia / Bleeding Problems : YES / NO

Artificial Heart Valves : YES / NO

Blood Disease : YES / NO

Congenital Heart Lesions : YES / NO

Heart Problems : YES / NO

Pacemaker : YES / NO
Arthritis / Rheumatism / Gout : YES / NO
Artificial Joints / Bones : YES / NO
Asthma : YES / NO

Cancer : YES / NO

Chemotherapy : YES / NO

Diabetes : YES / NO

Emphysema : YES / NO

Glaucoma : YES / NO

Radiation Treatment (X-Ray/Cobalt) : YES / NO

Shortness of Breath (Breathing Problems) : YES / NO

Sinus Trouble : YES / NO

Stroke : YES / NO

Thyroid Problems : YES / NO

Tuberculosis : YES / NO

Tumor / growth on head / neck : YES / NO

Ulcer : YES / NO

Epilepsy : YES / NO

Fainting / Dizziness : YES / NO

Headaches (Frequent) : YES / NO

Hepatitis : YES / NO

Herpes : YES / NO

Kidney Disease : YES / NO

Liver Disease : YES / NO

Nervous Problems : YES / NO

Psychiatric Care

List any other medical issues you have____

List any serious Illnesses / surgeries / hospitalizations__________________________________

List any medications you are taking____

Pregnant **: YES / NO**

Nursing : YES / NO

Signature: __________________________ Date: _______________

Name: ______________________ Date of Birth: ___________

Notice: X-rays and Insurance Coverage

We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

Signature: _______________________ Date: _____________