Patient Screening Form

Patient Name:

Date:

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

  [Yes No]
- Are you/they having shortness of breath or other difficulties breathing?

  [Yes No]
- Do you/they have a cough?

  [Yes No]
- Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?

  [Yes No]
- Have you/they experienced recent loss of taste or smell?

  [Yes No]
- Are you/they in contact with any confirmed COVID-19 positive patients?

  [Yes No]
- Is your/their age over 60?

  [Yes No]
- Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?

  [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]

Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.

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.

PROACTIVE DENTAL

Medical History / Patient Information Update

Patient Name: ____________________ DOB: ____________ Today's Date: ______________

HAS YOUR HOME ADDRESS / PHONE CHANGED? YES / NO

Address/City/Zip: ____

Home Phone: ____________________ Cell: ____________________ Work: ______________

Email Address: ____

HAS YOUR DENTAL INSURANCE CHANGE? YES / NO

Primary Subscriber: ____________________ SSN / Member ID: ______________ DOB: __________

Employer: ____________________ Insurance Name: ____________________

Insurance Group No: ____________________ Insurance Phone No: ____________________

1. Have you had or now have any Allergies?

Latex Allergy Yes / No Seasonal Allergies Yes / No

Food Allergies Yes / No

Drug Allergies Yes / No If other please List: ____________________

1. Are you taking any of the following Medications or any?

Nerve Pills Yes / No

Tranquilizers Yes / No Stimulants Yes / No

Pain Killer Yes / No Blood Thinners Yes / No

Muscle Relaxers Yes / No Insulin Yes / No

Please list other: ____

2. Do you have any history of Asthma or Breathing problems? Yes / No

   Have you been in the ER for an Asthma attack? Yes / No

   What Asthma medications do you take? ____________________

3. Please circle the following that apply:

Autism Spectrum	Yes / No	Thyroid Disease	Yes / No	Jaundice/Hepatitis	Yes / No
Sensory Integration Issues	Yes / No	Hearing/Vision Impediment	Yes / No	Prolonged Bleeding	Yes / No
ADD/ADHD	Yes / No	Eating Disorder	Yes / No	Nervousness	Yes / No
Heart Trouble/Murmur	Yes/ No	Abdominal Bleeding	Yes / No	Diarrhea/ Vomiting	Yes / No
Fever	Yes / No	Anesthesia Problems	Yes / No	Mumps Measles	Yes / No
Blood Disease/Anemia	Yes / No	Birth Defects	Yes / No	Cancer/Tumor/Cyst	Yes / No
HIV/AIDS/ARC Virus	Yes / No	Kidney Disease	Yes / No	Sinus Problems	Yes / No
Herpes Virus/ Shingles	Yes / No	Cleft Lip/ Palate	Yes / No	Tuberculosis	Yes / No
Compulsions/Seizures	Yes / No	Scarlet/High Fever	Yes / No	Diabetes	Yes / No
Ear/Nose/Throat Trouble	Yes / No	High/Low Blood Pressure	Yes / No	Leukemia	Yes / No
Stomach Ulcers	Yes / No	Liver Disease	Yes / No	Glaucoma	Yes / No
Heart Surgery/Pacemaker	Yes / No	Severe/Frequent Headache	Yes/ No	Scoliosis	Yes / No

Please list any other Medical Conditions or Surgeries: ______________________________________

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COVID-19 Pandemic Dental Treatment Consent Form

I, ______________________________, knowingly and willingly consent to have dental treatment/ hygiene 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 given the current limitations in virus testing. Dental procedures create water spray/aerosols which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of the 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. ________________________ (Initial)

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 COVID-19 virus, and the CDC recommends social distancing of at least 6 feet until further notice 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 airlines, bus, or train within the past 14 days. ___________ (Initial)

Name ____ Date __________________________