COVID-19 QUESTIONNAIRE

PATIENT DISCLOSURES: **Patient Name** _____ **Birth Date** _____

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	❑	❑
Have you experienced shortness of breath or had trouble breathing?	❑	❑
Do you have a dry cough?	❑	❑
Do you have a runny nose?	❑	❑
Have you recently lost or had a reduction in your sense of smell or taste?	❑	❑
Do you have a sore throat?	❑	❑
Have you been in contact with someone who has tested positive for COVID-19 in the past 14 days?	❑	❑
Have you been tested for COVID-19 in the past 14 days?	❑	❑
If so, date of test _____ and have you tested ❑ Positive ❑ Negative ❑ Awaiting Results		
Have you traveled outside the United States by air or cruise ship in the past 14 days?	❑	❑
Have you traveled within the United States by air, bus or train within the past 14 days?	❑	❑
Have you been vaccinated for COVID-19?	❑	❑
If you received the **Johnson & Johnson / Janssen** vaccine: Date of single dose vaccination _____		
If you received the **Moderna** or **Pfizer-BioNTech**: Date of 1st vaccination _____ Date of 2nd vaccination _____		
If you received a **booster** vaccine: Date of vaccination _____		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures can create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

Patient Acknowledgement:
I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Doctor**

X _____ **Date**

WELCOME TO OUR PRACTICE

PATIENT INFORMATION...

Date 12/27/2021

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age ____ Social Security Number _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ E-mail _____

Did you find our practice online? ❑ Yes ❑ No Referred By _____ (FIRST NAME) _____ (LAST NAME)

Have you ever been a patient of our practice? ❑ Yes ❑ No Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME)

Preferred Pharmacy _____ Tel.(_____) _____

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION...

Student: ..... ❑ Full Time ❑ Part Time ❑ Not ..... School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: .. ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: ..... ❑ Full Time ❑ Part Time ❑ Retired ❑ Not ..... Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY INSURANCE COMPANY...

Insurance Type: ❑ **Dental** ❑ **Medical**

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(_____) _____

SECONDARY INSURANCE COMPANY...

Insurance Type: ❑ **Dental** ❑ **Medical**

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(_____) _____

DENTAL INFORMATION...

Reason for today's visit _____ Are you in pain? ❑ Yes ❑ No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Red, swollen, or bleeding gums
❑ A removable dental appliance
❑ Blisters / sores in or around the mouth
❑ Prolonged bleeding from an injury / extraction
❑ Recent infections or sore throat
❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting
❑ Lost / broken filling(s)
❑ Teeth grinding / clenching
❑ Ringing in ears
❑ Broken / chipped tooth
❑ Gum disease
❑ Other _____
❑ Stained teeth
❑ Locking jaw
❑ Bad breath
❑ Burning tongue / lips
❑ Toothache
❑ Difficulty closing jaw
❑ Difficulty opening jaw
❑ Loose / shifting teeth
❑ Food caught between teeth
❑ Swelling / lumps in mouth

Last dental exam _____ Last dental x–rays _____ Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

MEDICAL HISTORY...

Patient Name _____

Are you in good health? ❑ Yes ❑ No • Height _____ Weight _____ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you ever had general anesthesia? ❑ Yes ❑ No • Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Problems with immune system *(possibly from med. / surg.)*	❑	❑	Blood transfusion	❑	❑	Contagious diseases
❑	❑	High blood pressure	❑	❑	Delay in healing	❑	❑	Blood disorder	❑	❑	Infectious mononucleosis
❑	❑	Low blood pressure	❑	❑	Hay fever / Sinus problems	❑	❑	Bruise easily	❑	❑	Swollen ankles
❑	❑	Mitral valve prolapse	❑	❑	Snoring	❑	❑	Eye disease / Glaucoma	❑	❑	Arthritis / Joint disease
❑	❑	Heart murmur	❑	❑	Sleep apnea / CPAP	❑	❑	Jaundice / Liver disease	❑	❑	Prosthetic implant
❑	❑	Chest pain / Angina	❑	❑	Respiratory problems	❑	❑	Hepatitis	❑	❑	Joint replacement
❑	❑	Heart attack(s)	❑	❑	Tuberculosis	❑	❑	Gallbladder trouble	❑	❑	Osteoporosis / Osteopenia
❑	❑	Irregular heart beat	❑	❑	Emphysema	❑	❑	Fainting spells	❑	❑	Osteonecrosis
❑	❑	Cardiac pacemaker	❑	❑	Do you smoke or vape *If so, how much a day*_____	❑	❑	Convulsions / Epilepsy	❑	❑	Stomach ulcers / acid reflux
❑	❑	Heart surgery				❑	❑	Stroke	❑	❑	GI troubles / IBS / Colitis
❑	❑	Damaged heart valves				❑	❑	Thyroid trouble	❑	❑	Tumor or growth
❑	❑	Pneumonia / Bronchitis / Chronic cough	❑	❑	Do you use chewing tobacco	❑	❑	Diabetes	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Chronic fatigue / Night sweat	❑	❑	A history of marijuana or other drug use	❑	❑	Low blood sugar	❑	❑	Are you on a diet
❑	❑	Trouble climbing 1-2 flights of stairs				❑	❑	Are you on dialysis	❑	❑	Contact lenses
❑	❑	Anemia	❑	❑	A history of alcohol abuse	❑	❑	Kidney trouble			
❑	❑	Asthma	❑	❑	Abnormal bleeding	❑	❑	Sexually transmitted diseases			
❑	❑	Mental health problems	❑	❑	Bleeding tendency	❑	❑	COVID–19			

MEDICATION & ALLERGIES...

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
									❑	❑	Blood thinners (Coumadin, Aspirin, Eliquis, Xarelto)
									❑	❑	Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	Do you have any known allergies

Please list any other medication or antibiotic you are allergic to:

MEDICATION / ANTIBIOTIC NAME	MEDICATION / ANTIBIOTIC NAME

Please list any allergies other than drug allergies:

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

Patient Name _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

❑ I permit the office to communicate with me via text message on my cell phone.

X _____ **X** _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**