Welcome!

Patient History

Please don't hesitate to ask if you have any questions

1. PATIENT INFORMATION

Patient Name _____
Last Name First Name Middle Initial

Date _____ Birthday _____

SS# or Insurance ID# _____ Sex ❑ M ❑ F

Address _____

City _____ State _____ Zip _____

Home Tel _____ Work Tel _____

Mobile # _____ Occupation _____

Email _____ Marital Status _____

Referral Source _____

Notes _____

2. EMPLOYER / SCHOOL

Employer/ School Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Notes _____

3. EMERGENCY CONTACT

Emergency Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Relationship _____

4. INSURANCE INFORMATION

Responsible Party Name _____

Relationship to Patient _____

Insurance Company _____

Subscriber Name _____

Group # _____ SS# _____

Birthday _____ Other Coverage ❑ Yes ❑ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with:

_____

and assigned directly to Dr. _____ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information in the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan to completed or one year from the date signed below.

Signature _____ Date _____

Please Continue to 2nd Page

Welcome!

Patient History Page 2

Please don't hesitate to ask if you have any questions

6. HEALTH HISTORY

Physician Name _____ Physician Tel _____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentennlne), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type __	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
		Do you wear contact lenses?	☐ Yes ☐ No		

Women: Are you pregnant? ☐ Yes ☐ No If yes due date: _____ Are you nursing? ☐ Yes ☐ No

7. MEDICATION & ALLERGIES

Please list all the medication you are currently taking _____

_____

_____

_____

Please list any known allergies _____

_____

Are you allergic to any of the following? ☐ Yes ☐ No

If yes please circle: Aspirin, Barbiturates (Sleeping pills), Codeine, Iodine, Latex, Local Anesthetic, Penicillin

Any other allergies? ☐ Yes ☐ No

8. UPDATES (for future visits)

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

COVID-19 PATIENT SCREENING FORM

Our records indicate you have an upcoming appointment with our office on _____.

Due to the COVID-19 global pandemic, we ask that you complete this form prior to arriving at our office and return it to us via email at (office email address).

We will not be able to accommodate your appointment without having received this before you arrive for your appointment.

In order to safeguard our dental office and the rest of our community, we ask that you arrive at the office wearing a face mask. You will not be allowed entry without a face mask. If we have an adequate patient protective equipment (PPE) supply, we will provide you with a new face mask before you leave our office.

If you are experiencing any symptoms related to COVID-19, we ask that you do not come to our office at this time. Symptoms are indicated below:

Cough, shortness of breath, or difficulty breathing

Or any two of the following:
Fever
Chills
Repeated shaking with chills
Muscle pain
Headache
Sore throat
New loss of taste or smell

This list is not all inclusive.

Please consult your medical provider if you have any other severe symptoms that concern you.

If you develop any of the following symptoms (warning signs) for COVID-19, seek emergency medical attention immediately:

Trouble breathing
Persistent pain or pressure in the chest
New confusion or inability to arouse
Bluish lips or face

If you are unable to print this form and email it, please copy and paste the questionnaire into a composed email and send it to the email address above.

PATIENT QUESTIONNAIRE

1. Have you traveled anywhere recently that are locations of disease outbreak?

2. Have you been in contact with anyone who was sick?

3. Have you attended any large group functions?

4. Have you had any of the following symptoms within the last two weeks: fever, fatigue, dry cough, altered taste, altered smell, trouble breathing, productive cough (mucous in cough), or muscle pain?

5. Have you previously had the SARS-COV-2 virus (novel coronavirus)? If so, did you test positive and what test were you administered?

6. Are you over the age of 65 and/or have preexisting health conditions related to the following: diabetes, chronic lung disease or asthma, serious heart condition, immunocompromised, or chronic kidney or liver disease?

We thank you for your cooperation and will contact you if we need further information.

Thank you,

Dr. _____