Patient Screening Form

Patient Name

	Pre-Appointment	In-Office
Date		

PATIENT SCREENING

Question	Pre-Appointment	In-Office
Have you/they been vaccinated for SARS-CoV-2 (COVID-19)?	○Yes ○No	○Yes ○No
Have you/they recently received a booster shot for COVID-19?	○Yes ○No	○Yes ○No

If yes, when was your/their last shot?

Which vaccination did you/they receive?

Question	Pre-Appointment	In-Office
Have you/they recently tested for COVID-19?	○Yes ○No	○Yes ○No

If yes, please specify test date

Question	Pre-Appointment	In-Office
Have you/they tested positive for COVID-19?	○Yes ○No	○Yes ○No
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

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful response and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date

All parties involved agree that this document may be signed electronically. The electronic signatures appearing on this document are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

MEDICAL INFORMATION *For the following questions, please mark (X) your responses.*

	Yes	No
Are you currently under the care of a physician?	O	O

Physician Name

Phone

Address/City/State/Zip

	Yes	No
Are you in good health?	O	O
Has there been any change in your general health within the past year?	O	O

If yes, what condition is being treated?

Date of last physical exam

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	O	O

If yes, what was the illness or problem?

	Yes	No
Do you take any blood thinners?	O	O
Do you take aspirin on a regular basis?	O	O
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	O	O

If yes, please list all medications, including vitamins, natural or herbal preparations and/or diet supplements:

For the following questions mark (x) your responses

	Yes	No
Do you use controlled substances (drugs)?	O	O
Do you use tobacco (smoking, snuff, chew, bidis)?	O	O

If so, how interested are you in stopping?

O VERY O SOMEWHAT O NOT INTERESTED

	Yes	No
Do you drink alcoholic beverages?	O	O

If yes, how much alcohol did you drink in the last 24 hours?

WOMEN ONLY Are you:

	Yes	No
Pregnant?	O	O

Number of weeks

	Yes	No
Taking birth control pills or hormonal replacements?	O	O
Nursing?	O	O

	Yes	No
Joint Replacement: Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement?	O	O

If yes, date

If yes, have you had any complications?

Allergies: Are you allergic or have you had a reaction to:

	Yes	No
Local anesthetics	O	O
Aspirin	O	O
Penicillin or other antibiotics	O	O
Barbiturates, sedatives, or sleeping pills	O	O
Sulfa drugs	O	O
Codeine or other narcotics	O	O

	Yes	No
Metals	O	O
Latex (rubber)	O	O
Iodine	O	O
Hay fever/seasonal	O	O
Animals	O	O
Food/Other	O	O

If yes, please specify

FOR CHILD PATIENTS *(Continued)*

FATHER INFORMATION

Name

Date of Birth

Marital Status

○ Married ○ Single ○ Separated ○ Divorced ○ Widowed

Home Phone #

Cell Phone #

Driver's License Number

Mailing Address

City

State

Zip

Employer

Work Phone #

Social Security #

Email

LEGAL GUARDIAN INFORMATION *If the legal guardian, foster parent, or other has custody of the child, please fill this section.*

Name

Date of Birth

Marital Status

○ Married ○ Single ○ Separated ○ Divorced ○ Widowed

Home Phone #

Cell Phone #

Driver's License Number

Mailing Address

City

State

Zip

Employer

Work Phone #

Social Security #

Email

FAMILY INFORMATION

Please list other family members seen by us

Whom may we thank for referring you?

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Name of Patient/Legal Guardian

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Date

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FOR COMPLETION BY OFFICE

Comments:

INSURANCE INFORMATION

Do you have orthodontic coverage?

○ Yes ○ No

If yes, please fill out the Primary Dental Insurance section below.

PRIMARY DENTAL INSURANCE

Policy Holder

○ Self ○ Other

Policy Holder Name (if not patient)

Relationship to Patient

○ Self ○ Spouse ○ Parent ○ Legal Guardian ○ Partner ○ Other

If other, please specify

Name of Employer

Work Phone

Address of Employer

City

State

Zip

Policy Holder Date of Birth

Insurance Company

Insurance Group #

Insurance Plan #

Effective Date

DENTAL INFORMATION

For the following questions mark (x) your responses

	Yes	No
Are your teeth sensitive to cold, hot, sweets or pressure?..........	○	○
Does food or floss catch between your teeth?..........................	○	○
Is your mouth dry?..	○	○
Have you had any periodontal (gum) treatments?.....................	○	○
Have you ever had orthodontic (braces) treatment?..................	○	○
Have you ever had any problems associated with previous dental treatment?..	○	○
Is your home water supply fluoridated?..................................	○	○
Do you drink bottled or filtered water?...................................	○	○

If yes, how often?

○ DAILY ○ WEEKLY ○ OCCASIONALLY

	Yes	No
Are you currently experiencing dental pain or discomfort?.........	○	○

Chief Complaint

	Yes	No
Do you have earaches or neck pains?......................................	○	○
Do you have any clicking, popping, or discomfort in the jaw?....	○	○
Do you brux or grind your teeth?..	○	○
Do you have sores or ulcers in your mouth?..............................	○	○
Do you wear dentures or partials?..	○	○
Do you participate in active recreational activities?...................	○	○
Have you ever had a serious injury to your head or mouth?.......	○	○

Date of your last exam

What was done at that time?

Date of last dental x-rays

Reason for visit

Health History Form

Today's Date

PATIENT INFORMATION

Patient Name

Date of Birth

Marital Status

○ Married ○ Single ○ Separated ○ Divorced ○ Widowed

Age

Home Phone #

Cell Phone #

Driver's License Number

Mailing Address

City

State

Zip

Employer

Work Phone #

Social Security #

Email

FOR CHILD PATIENTS

Do you have legal custody of this child?

○ Yes ○ No

If not, legal guardian information:

Your relationship to the child?

○ Mother ○ Father ○ Legal Guardian ○ Foster Parent ○ Other

If the legal guardian, foster parent, or other has custody of the child, please fill out the Legal Guardian Information section.

MOTHER INFORMATION

Name

Date of Birth

Marital Status

○ Married ○ Single ○ Separated ○ Divorced ○ Widowed

Home Phone #

Cell Phone #

Driver's License Number

Mailing Address

City

State

Zip

Employer

Work Phone #

Social Security #

Email

MEDICAL INFORMATION *(Continued)*

Please mark (X) your response if you have or have had any of the following diseases or problems.

Condition	Yes	No
Heart murmur	O	O
Mitral valve prolapse	O	O
Artificial heart valves	O	O
Rheumatic fever	O	O
Cardiovascular disease	O	O
Angina	O	O
Arteriosclerosis	O	O
Congestive heart failure	O	O
Coronary artery disease	O	O
Damaged heart valves	O	O
Heart attack	O	O
Low blood pressure	O	O
High blood pressure	O	O
Congenital heart defects	O	O
Pacemaker	O	O
Rheumatic heart disease	O	O
Abnormal bleeding	O	O
Anemia	O	O
Blood transfusion	O	O
If yes, date		
Hemophilia	O	O
AIDS or HIV infection	O	O
Arthritis	O	O
Autoimmune disease	O	O
Rheumatoid arthritis	O	O
Systematic lupus erythematosus	O	O
Asthma	O	O
Bronchitis	O	O
Emphysema	O	O
Sinus trouble	O	O
Tuberculosis	O	O
Cancer/Chemotherapy/ Radiation treatment	O	O
Chest pain upon exertion	O	O
Chronic pain	O	O
Diabetes type I or type II	O	O
Eating disorder	O	O
Malnutrition	O	O
Gastrointestinal disease	O	O
GE Reflux/persistent heartburn	O	O
Ulcers	O	O
Thyroid problems	O	O
Stroke	O	O
Glaucoma	O	O
Hepatitis, jaundice, or liver disease	O	O
Epilepsy	O	O
Fainting spells/seizures	O	O
Neurological disorders	O	O
If yes, please specify		
Gag Reflex Sensitivity	O	O
Sleep disorder	O	O
Mental health disorders	O	O
If yes, please specify		
Recurrent infections	O	O
If yes, type of infection		
Kidney problems	O	O
Night sweats	O	O
Osteoporosis	O	O
Persistent swollen glands in neck	O	O
Severe headche/migraines	O	O
Severe/rapid weight loss	O	O
STDs/STIs	O	O
Excessive urination	O	O
ADD	O	O
ADHD	O	O
Sensory Processing Disorder	O	O
Oral Sensory Sensitivity	O	O

Question	Yes	No
Has a physician recommended that you take antibiotics prior to your treatment?	O	O
Do you have any disease, condition, or problem not listed above that you think I should know about?	O	O

If yes, please explain

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Phone

Pharmacy Address