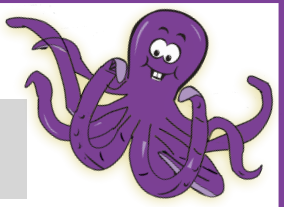
PATIENT INFORMATION (CONFIDENTIAL)



Patient's Name:

Home Address:

City: State: Zip:

DOB: / / Sex: ☐ Male ☐ Female SS #::

Cell Phone: Home Phone: Work Phone:

Email: Drivers Lic:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

Whom may we thank for referring you?

Name:

Home Address:

City: State: Zip:

DOB: / / Is this person currently a patient in our office? ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

Name of Insured:

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

DOB: / / Insured Social Security #:

Employer:

Address: _____

Address 2: _____

City, State, Zip: _____

Insurance Company:

Address: _____

Address 2: _____

City, State, Zip: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE?

☐ Yes ☐ No

IF YES, COMPLETE THE ADDITIONAL INFORMATION ON THE NEXT PAGE.

SECONDARY INSURANCE INFORMATION

Name of Insured:

Relationship to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other

DOB: / /

Insured Social Security #:

Employer:

Address: _____

Address 2: _____

City, State, Zip: _____

Insurance Company:

Address: _____

Address 2: _____

City, State, Zip: _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MONOR:

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No
Have you ever had a serious head or neck injury?	☐ Yes	☐ No
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No
Do you take, or have taken, Phen-Fen or Redux?	☐ Yes	☐ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No
Are you on a special diet?	☐ Yes	☐ No
Do you use tobacco?	☐ Yes	☐ No
Do you use controlled substances?	☐ Yes	☐ No

If you answered yes to any of the above, please explain:

Women: Are you: ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other? _____

MEDICAL HISTORY Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Angina	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Excessive Thirst	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Fainting Spells/Dizziness	☐ Yes	☐ No	Stomach Intestinal Disease	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Genital Herpes	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Heart Attack/Failure	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Heart Trouble/Disease	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Comments: Please list any disabilities:

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MONOR: Date:

PATIENT SCREENING FORM

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?	☐ 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

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

PATIENT SCREENING FORM

Thank you for you continued trust in our practice. As with the transmission of any communicable diseases like the cold or flu, you may be exposed to COVID-19 (Coronavirus) at any time or any place. Rest assured that we have always followed the infection control policies as stated by the state and federal regulations. We use universal precautions and the proper PPE to limit the transmissions of all diseases in our office and will continue to do so.

Despite our careful attention to sterilization, disinfection, and the use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. Social Distancing nationwide has reduced the transmission of the Coronavirus.

Although we have taken measures to provide social distancing in our practice due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental assistants and hygienist and sometimes other patients at all times. Exposure to the virus is very unlikely.

Do you accept the risk and consent to treatment?

- ☐ YES
- ☐ NO

Patient's signature/parent or guardian: _____

Date: _____