Health History & Covid-19 Update form for Hygiene Patients

To ensure the highest quality of healthcare, we ask that you complete this patient update form

Patient Name____Date:_____________________________

Home Address____

Home Phone Number_________________________-   Cell #______________________________

Email ____

Employer that covers your Insurance:____

Any Changes in Insurance?

Any Changes in health since your last dental visit?

What medications or supplements are you currently taking? (Prescription and/or non-prescription)

Are you allergic to any medication, foods or latex? PLEASE LIST

Female only: Are you pregnant?

Have you ever been told by your physician you need to take antibiotics before dental treatment?

Covid 19 Patient screening Questions

1. Do you have a fever above 100.4 F? Y N
2. Are you experiencing shortness in breath? Y N
3. Do you have a dry cough? Y N
4. Do you have runny nose? Y N
5. Have you recently lost or had a reduction in sense of smell or taste? Y N
6. Do you have a sore throat? Y N
7. Are you experiencing chills or repeated shaking with chill? Y N
8. Do you have unexplained muscle pain? Y N
9. Do you have headache? Y N
10. Have you been in contact with anyone who tested positive for Covid 19 in the last 30 days? Y N
11. Have you been tested for Covid 19 in the last 14 days? Y N
12. Have you traveled more than 100 mile from home in the last 14 days? Y N
13. Are you a residents of congregate living facilities? Y N
14. Are you a hemodialysis patients? Y N

I understand & acknowledge that I am fully responsible for the payment of all costs associated with the service, treatment, procedures and/or diagnostic methods performed by the dentist and others. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and myself, my spouse, my children and my employer.

As a courtesy to me, the dental office will bill my insurance company for services, treatment, procedures and/or diagnostic methods provided to me and I acknowledge that I will remain liable for any and all amount not paid by the insurance company for any reason. I acknowledge that it is my responsibility to provide the dentist with my current insurance information.

Patient Signature____ Dr./Staff Review___________________________