DR. DENTAL

ESTABLISHED PATIENT

DENTAL AND MEDICAL HISTORY UPDATE FORM

Today's Date*: _mm/dd/yyy___

Patient Full Name*: _____

Patients Date of Birth*: _ mm/dd/yyy_

Reason for Todays Visit: _____

Best Contact Number*: _123-456-789___ Email: _____

Any Changes in Mailing Address: _____

_____

	YES	NO	Provide update here
Any changes in insurance*?	☐	☐	
Any change in health since last dental visit*?	☐	☐	
Any surgeries or hospitalizations since last dental visit*?	☐	☐	
Any change in dental health since last dental visit*?	☐	☐	
Any new family history of cancer or other health issues*?	☐	☐	
Are you taking any new medications or supplements (prescription and/or nonprescription*)?	☐	☐	
Are you allergic to any medications, foods, or latex*?	☐	☐	

Do you use tobacco products*?	☐	☐	
Females Only: Are you pregnant?	☐	☐	
Females Only: Are you taking birth control?	☐	☐	

I certify *that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries 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.*

Patient Signature*: _____

Or Parent/Legal Guardian

DR. DENTAL

COVID-19 PANDEMIC DENTALTREATMENT NOTICE

AND ACKNOWLEDGEMENT OF RISK FORM*

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

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 create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non- essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are “potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection.” The ADA also recommends that urgent dental care which “focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments” be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above*:

Patient Name/ Legal Guardian Name*: _____

_____ _____

Patient /or/ Legal Guardian Signature* Today’s Date*

DR. DENTAL

COVID-19 PANDEMIC - PATIENT DISCLOSURES*

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? *	☐	☐
Do you have a sore throat? *	☐	☐
Have you been in contact with someone who has tested positive for COVID-19? *	☐	☐
Have you tested positive for COVID-19? *	☐	☐
Have you been tested for COVID-19 and are 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? *	☐	☐

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*.

Patient Name/ Legal Guardian Name*: _____

_____ _____

Patient /or/ Legal Guardian Signature* Today's Date*