Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
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?	☐ 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.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

NuLife Dental Clinic, Dr. MaryKaren Matt, DDS has put in place preventative measures to reduce the spread of COVID-19, however, the office cannot guarantee that you or your child(ren) ill not get infected with the COVID-19 virus.

By signing the agreement, I acknowledge the highly contagious nature of COVID-19 and voluntarily assume the risk that my chid(re) and I may be exposed to or infected by COVID-19 by coming to a dental office and such exposure or infection may result in personal injury, illness, permanent disability, and in extreme cases death. I understand that the risk of exposure or infection by COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, MayKaren Matt, DDS (NuLife Dental Clinic) or employees and that even the precautionary measures taken by MaryKaren Matt (NuLife Dental Clinic) may not be enough to stop the virus.

I voluntarily agree to assume all the foregoinig risks and accept sole responsibility for any injury to my child(ren) or myself (including but not limited to personal injury, disability, and death) critical illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may xperience or incur in connection with my dental work. On my behalf, and on behalf of my children, I herby release, covenant not to sue, discharge, and hold harmless MaryKaren Matt, DDS (NuLife Dental Clinic) its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of MaryKaren Matt, DDS(NuLife Dental Clinic), its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any dental work.

Signature of Patient Date

Print Name of Patient

Print Name of Dental Staff

Patient Registration

Patient's Name _____ Age _____ Birthdate _____ SS# _____

Name Of Spouse _____ Age _____ Birthdate _____ SS# _____

If CHILD, parent's names _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Email _____

Person Responsible for this account** _____

Dental Coverage (Yes/No) if yes--Insurance name _____ Employer: _____

ID# or SS# of insured _____ Mailing Address for Claims _____ Birthdate: _____

Do you have (2) dental coverages? Yes/No--If yes please repeat info from ** here: _____

_____

Whom may we thank for refering you to our practice? _____

Health History

Are you under the care of a physician? (Yes/No) If yes please explain _____

_____

Name & phone of physician treating your condition: _____

Women-Are you pregnant? If so, due date: _____

Have you had full mouth X-rays taken in the past 3 years? (Yes/No)

If so where and name of dentist & phone # _____

Are you ALLERGIC to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Local Anesthetics ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive	Y N	Chemotherapy	Y N	Hemophillia	Y N	Psychiatric Care	Y N
Alzheimer's Disease	Y N	Congenital Heart Disorder	Y N	Hepatitis A	Y N	Radiation Treatments	Y N
Anaphylaxis	Y N	Diabetes	Y N	Hepatitis B or C	Y N	Reflux	Y N
Angina	Y N	Drug Addiction	Y N	High Blood Pressure	Y N	Rheumetic Fever	Y N
Arthritis/Gout	Y N	Emphysema	Y N	High Cholesterol	Y N	Scleraderma	Y N
Artificial Heart Valve	Y N	Epilepsy and Seizures	Y N	Kidney Problems	Y N	Thyroid Disease	Y N
Artificial Joint	Y N	Fainting Spells/ Dizziness	Y N	Liver Disease	Y N	Transplant	Y N
Asthma	Y N	Hay Fever	Y N	Low Blood Pressure	Y N	Stroke	Y N
Blood Disease	Y N	Heart Attack/ Failure	Y N	Mitral Valve Prolapse	Y N	Tuberculosis	Y N
Blood Thinners	Y N	Heart Murmur	Y N	Osteoporosis	Y N	Ulcers	Y N
Bulimia	Y N	Heart Pacemaker	Y N	Pain in Jaw Joints	Y N	Venereal Disease	Y N
Cancer	Y N	Heart Trouble/Disease	Y N	Parathyroid Disease	Y N		

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

_____

HIPAA ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the "Notice of Private Practices" and understand I have a right to review prior to signing this document. You may refuse to sign this part of the document.

Parent/Guardian Signature: _____ Print Name: _____ Date: _____

Please list any MEDICATIONS you are taking and the dosage: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Sign _____ **Date** _____ **Sign** _____ **Date** _____

Sign _____ **Date** _____ **Sign** _____ **Date** _____

Sign _____ **Date** _____ **Sign** _____ **Date** _____

Sign _____ **Date** _____ **Sign** _____ **Date** _____

Sign _____ **Date** _____ **Sign** _____ **Date** _____