COVID-19 SCREENING QUESTIONNAIRE

All patients must have a screening form completed before your appointment.

Print Name: _____

Please review the following self screening criteria:

	Yes	No
Has the patient or anyone in the family (household) tested positive for COVID-19?	☐	☐
Has the patient or anyone in the family (household) been tested for COVID-19 and are awaiting results?	☐	☐
Does the patient or anyone in the family (household) have any of the following respiratory symptoms? Fever, Sore Throat, Cough, Shortness of Breath?	☐	☐
Has the patient or anyone in the family (household) recently lost your sense of smell or taste?	☐	☐
Does the patient or anyone in the family (household) have any GI symptoms? Diarrhea? Nausea?	☐	☐
Even if you don't currently have any of the above symptoms, has the patient or anyone in the family (household) experienced any of these symptoms in the last 14 days?	☐	☐
Has the patient or anyone in the family (household) been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐	☐
Has the patient or anyone in the family (household) traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Has the patient or anyone in the family (household) traveled within the United States by air, bus or train within the past 14 days?	☐	☐

- **If *answered YES to any of the above questions, your appointment will be rescheduled.***

If you do not meet the criteria above, please sign below indicating that you have been provided with this information.

I HAVE REVIEWED THE ABOVE CRITERIA AND I DO NOT HAVE SYMPTOMS AS DESCRIBED. PLEASE SIGN AND DATE

Signature: _____Date: _____

☐ TEMPERATURE UPON ARRIVAL

Patient Information

First Name: _____ Last Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: M / F Birth Date: ___ /___ /_____ SS#:_____ DL # _____

Family Status (circle): Single Married Divorced Child

Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other:_____	

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

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Birth Date: ___ /___ /_____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Home #: _____ Work #: _____ Mobile #: _____

Insurance Information (Primary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No
_____
3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____

4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction? Please Circle

Local Anesthetics	Penicillin/other Antibiotics	Barbituates, Sedatives or Sleeping Pills	Latex Rubber	Iodine
Aspirin	Codeine/Other Narcotics	Acrylic	Sulfa Drugs	Other (Please write)

7. Please list other medications you are taking:
_____
_____

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A	Yes No	Hay Fever	Yes No
Psychiatric					
Treatment	Yes No	Hepatitis B	Yes No	Tobacco Products	Yes No
Sickle Cell Disease	Yes No	Hepatits C or D	Yes No	Bruise Easily	Yes No
Sinus Trouble	Yes No	Pacemaker	Yes No	Jaundice	Yes No
Artificial Joints	Yes No	Night Sweats	Yes No	Kidney Trouble	Yes No
Thyroid Disease	Yes No	Stroke	Yes No	Diabetes	Yes No
Anemia	Yes No	Drug Addiction	Yes No	Chemotherapy	Yes No
Blood Transfusion	Yes No	Cold Sores	Yes No	Cancer	Yes No
Mitral Valve Prolapse (MVP)	Yes No	Radiation Therapy	Yes No	Transplant	Yes No

Health Insurance Portability Act Acknowledgement Form (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize EPIC WEST FAMILY DENTISTRY to use and disclose my protected health information to carry out:

- } Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- } Obtain payment from third party payers (e.g. my insurance company); and,
- } The day-to-day healthcare operations of your practice.

I have also been informed of, and have been given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more completed description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. IF NO INSURANCE, WRITE NO INSURANCE, PLEASE INITIAL AND SIGN FOR FUTURE REFERENCES. If you do have insurance later on in the future, you will have to sign a new HIPAA form again.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to EPIC WEST FAMILY DENTISTRY all insurance benefits, if any, otherwise payable to me for services rendered. I understand that their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.
I understand that I am responsible for my balance if any of the following occur:

A. The treatment that is proposed is more than my annual maximum.
B. My insurance denies any treatment.
C. I am not eligible for dental benefits.
D. I prevent or delay payment by not complying with the requirements of signatures on forms or any documents required by my insurance or doctor's office.
E. I do not finish my treatment and as a result my insurance does not pay for my treatment.
F. Lab fees that may accumulate for missing my appointments
G. I receive an insurance check for the services that were rendered and I did not forward it to the dental office.

If my insurance has not paid my dental claim after 30 days of services rendered, it is my responsibility to call the insurance carrier and see why they have not paid my claim.

I accept all treatment that has been proposed and authorize that any information that is necessary regarding this dental claim. I understand the policy of EPIC WEST FAMILY DENTISTRY regarding my insurance and my responsibility for the service that were rendered. I have read and understand my duties to accept my insurance for payment for my dental services.

Signature of Patient, Guardian: _____ Date: _____

Cancellations and Missed Appointments

We strive to create a schedule that most efficiently provides excellent dental care to all of the patients we serve. When an appointment is scheduled, that time has been set aside for you. When it is missed, that time cannot be used to treat another patient.

****Please arrive on time to your scheduled appointment. Late arrivals, more than 15 (fifteen) minutes after the scheduled time, causes delays for those patients who arrive promptly for their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day. Cancellations later than 48 hours or NO CALL/NO SHOW patients will be charged a fee of $25. Our office policy is absolutely firm in this regard.****

The missed appointment will be charged The Missed Appointment/Cancellation fee of $25, noted in the patient's chart and is considered missed if

1. The patient fails to show up for the appointment
2. The patient is more than 15 minutes late for a scheduled appointment without a phone call made to the dental clinic
3. The patient calls to cancel an appointment without giving a 48-hour notice

If a patient has two missed or cancelled appointments without proper notice in a six-month period, the patient will only be seen on an emergency basis or walk-in only.

As always, if you cancel 48 hours in advance by talking directly to our office staff, it will not be considered a missed or cancelled appointment.

I have read and understand the Appointment Cancellation Policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____
Print Name of Patient

_____

_____
Signature of Patient or Guardian Date

DENTAL TREATMENT CONSENT FORM

*Patient Name:*_____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned procedure so that you can decide whether to have a procedure or not after knowing the risks, benefits and alternative options.

I understand that good oral hygiene is essential to prevent decay and to assist in the successful treatment of dental conditions.

1. EXAM/X-RAYS/CLEANING/SEALANTS

I give the dentist/dental office permission for my routine examination, x-rays, prophy (cleaning), and sealants.

(Initials _____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics, pain medications, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. I know it is important to take any medicines that are prescribed for me as directed to help minimize potential problems. Certain medications may cause drowsiness and I should not drive or operate hazardous equipment when using such drugs. If I have a problem, I should get appropriate medical care from either my doctor or in emergencies by calling 911.

(Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that, during treatment, it may be necessary to change or add procedure(s) because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

(Initials_____)

I understand that dentistry is not an exact science and that, therefore; reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient/Guardian _____ Date_____

Consent for Email and / or Text Communication

I hereby give Epic West Family Dentistry permission to contact me in regards to confirming and scheduling appointments. Please list a valid email address and cell phone number where you would like to receive correspondence.

___ Email _____

___ Text (cell phone number) _____

Consent for an individual to Access My Dental Records

I hereby give the following individual(s) permission to access and view my dental record. If I am over the age of 18, I must list the names of those individuals that I would like my dental information shares with this includes but is not limited to spouses, parents, siblings, children, ext. Epic West Family Dentistry will not be allowed to share information of discuss details of treatment with an unauthorized person.

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

_____

Signature of Patient