Covid Patient Screening Form

Patient Name:____ Date:__________

Temp:	**Pre- Appointment Assessment**	
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes	No
Are you/they having shortness of breath or other difficulties breathing?	Yes	No
Do you/they have a cough?	Yes	No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes	No
Have you/they experienced recent loss of taste or smell?	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
Is your/their age over 60?	Yes	No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	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

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

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Patient Information

Patient Name: ______________________________ Date: __________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other e-mail: __________

Social Security #: __________ Birth Date: __________

Phone (Home): __________ **(Work):** __________ **Ext:** ______ **Cell #**

Best time to call: ______ Preferred appointment times: ☐ AM ☐ PM ☐ Evening ☐M ☐T ☐W ☐T ☐F ☐S

Address: ______________________________
Street Apartment #

____
City State Zip Code

Office policy: I, understand that there will be a $25 cancellation fee charged per patient for any appointments cancelled with less than 24hours notice. We appreciate your understanding.
Initial X __________

Health Information

Please check those that apply:

☐ HIV
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: ______
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems

☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Smoking/Tobacco
☐
☐
☐

ALLERGIES: Circle those that apply: Penicillin, Aspirin, Codeine, Iodine, Latex, Anesthetics, Sulfa, NONE

Other Allergies: ______________________________

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, name of Physician: ______________________________
- List of Medications: ______________________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ Date __________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient

☐ Dental Office ☐ Google ☐ Social Media ☐ Yelp ☐ Other __________

Name of person or office referring you to our practice: ______________________________

Responsible Party Information (Please fill out if patient is under 18 years of age)

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: ____________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

Employer Name: ____________________ Occupation: ____________________

Address: ____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____

____

Assignment and Release

I certify that I have answered all questions correctly and to the best of my knowledge. I certify that I and/or my dependent(s) have insurance coverage with ____________________ and assign directly to Supreme Dental and its associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ____________

Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ____________

Signature of guarantor of payment/responsible party

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Patient Name ______________________________

Dental Consent Form

- **WORK TO BE DONE**

  I understand that I am having the following work done: Exam and X-rays.

  Initial ____________

- **DRUGS AND MEDICATIONS**

  I understand that antibiotics and analgesics and other medication can cause allergic reaction causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

  Initial ____________

- **CHANGES IN TREATMENT PLAN**

  I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on 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.

  Initial ____________

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 ______________________ **Relationship** ______________________ **Date** ________
Patient or legal representative

Doctor ______________________________ Witness ______________________________

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Financial Policy

Thank you for choosing **Supreme Dental** for your dental care. We are committed to providing excellent dental care with convenient financial arrangements. We kindly ask that you read and understand this policy prior to treatment to assure there is full disclosure of payment options and expectations.

If you have Dental Insurance.

- Our office is committed to helping patients maximize their benefits.
- Your dental insurance is a three way contract between you, your employer and your dental insurance provider.
- If we are a contracted provider, which means that we agree to contracted fees and terms that your insurance company has presented to us, we will provide you with a breakdown of explanation of benefits as well as a complete estimate of what your financial responsibility will be.
- There may be a maximum allowed per year, limitations, frequencies and exclusions on your plan.
- There may be a deductible and/or copayment that is due at time of service.
- We do our best to give you the most accurate estimate of your insurance benefits, however, insurance reimbursement is not guaranteed.
- We may bill you any portion of the service that is not paid by your insurance.
- In the event that your account is turned over to a collections agency for non-payment or delinquency, you will be responsible for payment of any collection cost, in addition to the balance owed.

If you do not have Dental Insurance.

- Our in house discount plan is guaranteed competitive and affordable.
- We will explain your treatment options and financial obligations clearly.
- Full payment is expected at time of service unless prior financial arrangement is made.
- We accept Cash, Visa/MC, Discover, AMEX
- We offer prepayment discount and treatment package discount
- We offer financing through CareCredit *(Ask for details)*
- In the event that your account is turned over to a collections agency for non-payment or delinquency, you will be responsible for payment of any collection cost, in addition to the balance owed.

Printed Name of Patient/Responsible Party: ______________________________

Signature of Patient/Responsible Party: ______________________________

Date: ______________________________

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ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, ________________________________ have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign.

Communication barriers prohibited obtaining the acknowledgment.

A emergency situation prevented us from obtaining acknowledgment.

Other (Please Specify)

____
____
____
____
____