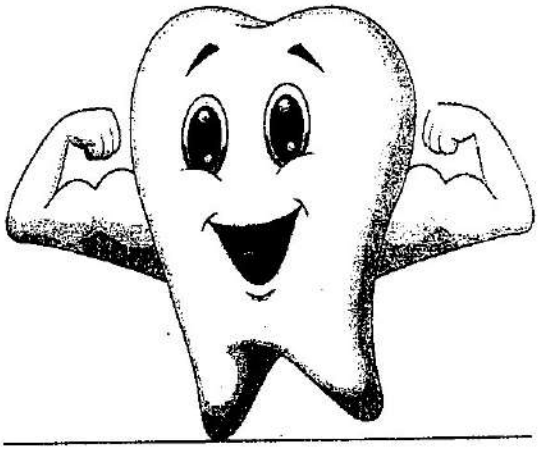
Patient Screening Form

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 to any regions affected by COVID-19? (as relevant to your location)	☐ 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.



Welcome to Terrery Dentall

Our dental team is happy to welcome you to our practice. We are pleased that you have chosen us to care for your dental needs. We are committed to providing you with high quality dental care in a caring, gentle manner.

You will need to provide us with the following:

- Photo identification
- Insurance cards

On your first visit you can expect:

- An introduction to our office and staff
- A thorough examination and assessment of your oral health, including necessary x-rays
- A discussion of the most satisfactory treatment plan to meet your oral health goals

Please remember that you are responsible for payment at time of service. Any co-pays and deductibles are due at time of service. If you have any financial questions please contact the office manager.

We recognize the value of your time, except in emergency situations, you can expect us to be on time for you. We would appreciate the same courtesy. To avoid a $25.00 cancellation fee our office requires at least 48 hours' notice for any cancellations.

Patient/guardian signature_____ Date_____

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____
Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address *(if different from patient)* _____ Home Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address *(if different from patient)* _____ Soc. Sec. # _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Subscriber Employed by _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑Y ❑N Bad breath
❑Y ❑N Bleeding gums
❑Y ❑N Clicking or popping jaw
❑Y ❑N Food collection between teeth
❑Y ❑N Grinding or clenching teeth
❑Y ❑N Loose teeth or broken fillings
❑Y ❑N Periodontal treatment
❑Y ❑N Sensitivity to cold
❑Y ❑N Sensitivity to hot
❑Y ❑N Sensitivity to sweets
❑Y ❑N Sensitivity when biting
❑Y ❑N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑Y ❑N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑Y ❑N

If yes, describe _____

Are you currently under physician care? ❑Y ❑N If yes, describe _____

Have you ever had a blood transfusion? ❑Y ❑N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑Y ❑N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑Y ❑N

Women: Are you pregnant? ❑Y ❑N Nursing? ❑Y ❑N Taking birth control pills? ❑Y ❑N

Check (✓) yes or no whether you have had any of the following:

❑Y ❑N AIDS/HIV Positive
❑Y ❑N Anaphylaxis
❑Y ❑N Anemia
❑Y ❑N Arthritis, Rheumatism
❑Y ❑N Artificial heart valves
❑Y ❑N Artificial joints
❑Y ❑N Asthma
❑Y ❑N Atopic (allergy prone)
❑Y ❑N Back problems
❑Y ❑N Blood disease
❑Y ❑N Cancer
❑Y ❑N Chemical dependency
❑Y ❑N Chemotherapy
❑Y ❑N Circulatory problems
❑Y ❑N Cortisone treatments
❑Y ❑N Cough, persistent
❑Y ❑N Cough up blood
❑Y ❑N Diabetes
❑Y ❑N Epilepsy
❑Y ❑N Fainting
❑Y ❑N Food allergies
❑Y ❑N Glaucoma
❑Y ❑N Headaches
❑Y ❑N Heart murmur
❑Y ❑N Heart problems
Describe _____
❑Y ❑N Hemophilia/ Abnormal bleeding
❑Y ❑N Herpes
❑Y ❑N Hepatitis
❑Y ❑N High blood pressure
❑Y ❑N Jaw pain
❑Y ❑N Kidney disease or malfunction
❑Y ❑N Liver disease
❑Y ❑N Material allergies **(latex**, wool, metal, chemicals)
❑Y ❑N Mitral valve prolapse
❑Y ❑N Nervous problems
❑Y ❑N Pacemaker/ Heart surgery
❑Y ❑N Psychiatric care
❑Y ❑N Rapid weight gain or loss
❑Y ❑N Radiation treatment
❑Y ❑N Respiratory disease
❑Y ❑N Rheumatic/Scarlet fever
❑Y ❑N Shingles
❑Y ❑N Shortness of breath
❑Y ❑N Skin rash
❑Y ❑N Spina Bifida
❑Y ❑N Stroke
❑Y ❑N Surgical implant
❑Y ❑N Swelling of feet or ankles
❑Y ❑N Thyroid disease or malfunction
❑Y ❑N Tobacco habit
❑Y ❑N Tonsillitis
❑Y ❑N Tuberculosis
❑Y ❑N Ulcer/Colitis
❑Y ❑N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Terrery Dental

3180 Rte. 611

Fountain Court, Suite 14

Bartonsville,PA 18321

PATIENT HIPAA CONSENT FORM

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 you 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);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of our practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of privacy Proctices*, which contains a more complete 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 this 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 health care operation, but you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

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

Signed this_____day of_____20_____

Print Patient Name_____

Signature_____

Patient HIPPA Release Form

The Health Insurance portability & Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, weather electronically, on paper or orally be kept confidential.

A copy of this policy is available to you at your request.

All doctors and staff at Terrery Dental may release information on your health to the following individuals.

Name_____ Relationship_____

Name _____Relationship_____

Patient Name _____Signature _____Date_____

Terrery Dental

3180 Rte.611

Fountain Court, Suite 14

Burtonsville, PA 18321