# 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.

DATE 5/7/2008

# PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

**Responsible Party (if someone other than the patient)**

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

**Patient Information**

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 Section 3

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Physicians Name: _____

Refer In: _____

Emergency Contact: _____

Emergency Phone Numb: _____

**Primary Insurance Information**

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

**Secondary Insurance Information**

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

# HEALTH HISTORY

English

Patient Name:_____ Patient Identification Number:_____

Birth Date:_____

**I. CIRCLE APPROPRIATE ANSWER** (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____ Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

**II. HAVE YOU EXPERIENCED:**

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

**III. DO YOU HAVE OR HAVE YOU HAD:**

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma, TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: drugs, foods, medications, latex?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

**IV. DO YOU HAVE OR HAVE YOU HAD:**

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

**V. ARE YOU TAKING:**

61. Yes No Recreational drugs?
62. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

Please list:_____

_____

**VI. WOMEN ONLY:**

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?

**VII. ALL PATIENTS:**

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

*To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.*

Patient's signature:_____ Date:_____

**RECALL REVIEW:**

1. Patient's signature_____ Date:_____
2. Patient's signature_____ Date:_____
3. Patient's signature_____ Date:_____

# PATIENT CONSENT TOO TREATMENT

**In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.**
**(Initial)** _____

**[ ] 1. DRUGS MEDICATIONS AND ANESTHESIA:**

I understand that antibiotics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness, and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate and vehicle or hazardous device while taking medications and/or drugs. I have been advise not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of a lease twenty-four [24] hours after my release from surgery.

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation to the area of injections.

I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloryl hydrate, "Zanax", or any other sedative, possible risks include, but are not limited to, loss of conciousness, obstruction of airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side affects, such as obstruction or airway. **(Initial)** _____

**[ ] 2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):**

I understand that the long term success of treatment and status of my oral conditions depends on my efforts at proper oral hygiene (i.e. Brushing and flossing) and maintaining regular recall visits.

PERIODONTICS - I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatment have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.
**(Initial)** _____

**[ ] 3. REMOVAL OF TEETH**

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this conditions persists with out treatment or surgery, my present oral conditions will probably worsen in time.

Potential risks include, but are not limited to, the following:

A. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery.

B. Injury to adjacent teeth, caps, or fillings (requiring the recementation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not with in the described surgical area.

C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite or temporomandibular joint (jaw point) difficulty (possibly requiring physical therapy or surgery.

D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.

E. Possible bone fracture which may require wiring or surgical treatment.

F. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side; this may persist for several weeks, months, or, in remote instances, permanently. **(Initial)** _____

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary to advisable as necessary to complete the planned operation. **(Initial)** _____

If any unforeseen conditions should arise in the course of the operations, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever (s)he may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility. **(Initial)** _____

**[ ] 4. FILLINGS**

I have been advised of the need for filling, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time filling will need to be replace due to wearing of material. In case where very little tooth structure remains, or existing tooth structure and built-up, and crowns which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and, as such, is a treatment used by Pico Dental Group. The advantages and disadvantages of alternate materials. **(Initial)** _____

**[ ] 5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY)**

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatment, and the consequences of non treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth.

I understand that treatment risks can include, but are not limited to the following:

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.

B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.

C. Infection

D. Restricted jaw opening.

E. Breakage of root canal instruments during treatment, which may in the judgment of the doctor be left in the treatment root canal or bone as part of the filling material; or it may require surgery for removal.

F. Perforation of the root canal with instrument, which may require additional surgical treatment or result in premature tooth loss or estraction.
G. Ridsk of temporary or permanent numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal theraphy. If root canal treatment is not finalized I expose myselt to infection and/or tooth lose.

If failure of root canal theraphy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

(INITIAL)_____

**[ ] 6. CROWN AND BRIDGE (CAPS):**

I understand that sometimes it is not possible to match the color natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposur may accour, necessitating possible root canal therapy.

I understand that like natural teeth, crowns and bridges need to be kept clean, eith proper oral hygiene and periodic cleaning, otherwise decay may develop underneath and/or the margins of the restotation, leading to further dental treatment.

(INITIAL)_____

**[ ] 7. DENTURES- COMPLETE OR PARTIAL:**

The problems of wearing dentures has been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori[bone] removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never may never be able to wear dentures to my satisfaction.

(INITIAL)_____

**[ ] 8. PEDODONTICS (CHILD DENTISTRY):**

I understand that the following procedures are routinely used at Pico Dental Group, as well as being accepted procedures in the dental profession.

A. POSITIVE REINFORCEMENT - Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.

B. VOICE CONTROL - The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctors voice.

C. PHYSICAL RESTRAINT - Restraining the child's disruptive movement by holding down their hands, upper body, head, and/or legs by use of the denstist's or assistant's hands or arm, or by use of a special device (referred to as a "papoose board").

D. NITROUS OXIDE AND/OR SEDATION - Nitrous Oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the parent/or guardian must understand that the child should <u>not</u> eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

(INITIAL)_____

I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bite theirlip causing injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

(INITIAL)_____

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPSOED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTORS WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO QUESTIONS, AND HAVE HAD THEM ANSWERES TO MY SATISFACTION.

I UNDESTAND THAT PICO DENTAL GROUP PROVIDES DENTAL CARE SERVICE WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS.

Signature: _____ Relationship _____ Date: ____/____/____

Patient or Legal Representative

Doctor: _____ Witness: _____