HELLO AND WELCOME TO OUR OFFICE!

We are delighted to have you here. Please answer the following questions as completely as possible. If you need any assistance, please ask.

Thank you very much.

Name: _____

Home Address: _____ **Apt.** _____ **SSN:** _____

_____ **ZIP** _____

Home: _____

Work phone: _____

Cell phone: _____

Email Address _____

Your Birth Date: _____

What kind of work do you do? _____

If you have another occupation(s) as well, please list: _____

Are you married, single, widowed or partnered? _____

Spouse/partner/guardians name, occupation and daytime phone number: _____

_____

Who may we thank for referring you? _____

Why have you come to see us today? _____

Are you having any pain or discomfort at this time? _____ **If so, where?** _____

Are you at all anxious about today's appointment? _____ **If so, why?** _____

Are you happy with your smile? ____ **If not, why? (please circle)**
LONG **SHORT** **DARK**

CROWDED **CROOKED**

Would you like to know more information about straightening your teeth with INVISALIGN?
Yes ( ) No ( )

Is your breath ever unpleasant? _____ If so, when? _____

Do you floss? _____ How often?_____

How often do you brush your teeth? _____

Do you smoke? _____ Do you have frequent headaches? _____ Are You Pregnant? Y or N

Have you ever been screened for oral cancer? _____

Have you ever had orthodontic treatment? _____

Does food wedge between any of your teeth? _____ If so, where?_____

Do your gums bleed when you (please circle) Floss Brush Eat Other _____

Does your jaw ever (please circle) Hurt Click Pop? At what time of day? _____

Do you (please circle) Clench Grind your teeth? At what time of day? _____

Are your teeth sensitive to (please circle) Hot Cold Sweets Air Chewing Biting

Are you aware of any swelling or lump(s) in your mouth? If so, where? _____

Do you have missing teeth? _____

Is your denture or partial comfortable? _____

Anything about them you would change? _____

If you have left another practice, what did you not like about your past dental appointments?

- **( ) Have you moved?**
- **( ) Was the treatment uncomfortable?**
- **( ) Was the team unfriendly?**
- **( ) Were the fees not explained before your appointments?**
- **( ) Anything we have not thought of? _____**

Have you ever been told that you need to take antibiotics prior to dental treatment? _____

Are you allergic to any medications? ____ Which ones? _____

Your Pharmacy name and phone number: _____

Do you have or have you had any of the following? Please circle all that apply:

Any heart problems	**High/ Low blood pressure**	**Infertility Treatments**	**Circulatory problems**	**Nervous problems**
Cancer	**Radiation treatments**	**Excessive bleeding**	**HIV**	**AIDS**
Anemia	**Arthritis**	**Asthma**	**Diabetes**	**Hepatitis**
Herpes	**Measles/Mumps**	**Cosmetic Surgery**	**Psychiatric Care**	**Rheumatic Fever**
Scarlet Fever	**Sinus problems**	**Stroke**		**Tuberculosis**
Ulcer	**Venereal Disease**	**Candidiasis**	**Joint Replacement**	**Reaction to dental anesthetic**
Seasonal allergies	**Migraine headaches**	**Snoring**	**Thyroid disease**	**Gum Surgery**
High Stress		**Chemotherapy**	**Facial surgery**	**Current Pregnancy**

Anything not listed? _____

Is there anything else that you would like us to know about your medical/dental history?

_____

_____

Please list any medications that you take and why_____

_____

Do you have dental "insurance"? _____.

If so, please provide the name, address and phone number of your carrier as well as your policy number, so that we may submit your claim for Dental benefits on your behalf.

_____

_____

_____

In our office we like to photograph our patients for aid in determining their needs and help come up with the perfect treatment options for them. With these photographs, we can recreate your smile on the computer so that you can see the final results and approve of them before we start any procedure.

I _____ __, hereby authorize Dr. Ira Newman to take photographs, slides of my face, jaws and teeth. I understand that the photographs and slides will be used as a record of my care.

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 (HIPPA). 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 the treatment);
Obtaining payment form third party payers (e.g. my insurance company)
The day-to-day healthcare operations of your practice.

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 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 or disclosure that occurred prior to the date I revoke this consent is not affected.

"I state that I have answered all the questions completely, and that I will inform Dr. Newman of any change in my medical status. I also understand that payment is due at time of service, and that if I have dental insurance, Dr. Newman's office will process my claim form for me if I so choose and that I will be reimbursed by my insurance company to the extent that my policy allows."

Signed: _____ ***Date:*** _____ ___

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.