Andrew Barnett, DMD, MS **Marshal Goldberg, DDS, MS**

Patient Name:_____ **Date:**_____

MEDICAL HISTORY

Date of last complete physical exam_____Height_____Weight_____

DO YOU HAVE or HAVE YOU HAD:

	Yes	No
Hepatitis or liver disease…….		
Epilepsy, convulsions, or seizures……..		
Rheumatic fever……..		
Kidney or bladder disease……...		
Diabetes……..		
Bronchitis, emphysema, or tuberculosis...		
Heart attack…….		
Heart trouble……...		
Heart murmur……..		
Stroke……..		
High/low blood pressure (circle which)……..		
Shortness of breath/swollen ankles…….		
Chest pains (angina)……		
Osteoporosis/osteopenia…….		
Allergies……..		
Cancer…….		
Chemotherapy/radiation therapy…….		
Hospitalization for illness or injury……		
Surgery……...		
Glaucoma……..……..…		
Hemophilia……..		
Arthritis……...		
Lupus……..		
Psychiatric treatment……..…..		
Thyroid trouble……...		
Stomach ulcers……		
Sinus problems……		
Asthma……		
Anemia……...…….		
Heart valve replacement……		
Hip or knee replacement (circle which)……..		
Other prosthetic joint or device……..……		
HIV positive……		

Any serious illness not listed?_____

_____

IF FEMALE, ARE YOU NOW:

	Yes	No
Pregnant……..….		
Taking birth control pills……..……..		
Through menopause……..……..		

HAVE YOU HAD AN UNFAVORABLE REACTION TO:

Latex……..		
Aspirin, ibuprofen, naproxen, NSAIDS….		
Acetaminophen (Tylenol)…….		
Tramadol, codeine, hydrocodone …….		
General anesthetics……		
Local (dental) anesthetics……...……		
Penicillin or amoxicillin……...		
Clindamycin…….……..		
Tetracycline or doxycycline……..…..		
Sulfa....……...….		
Valium.……...….		
Steroids...……		
Any other medications……		

Which: _____

_____

ARE YOU:

Presently under a physician's care…….		
Subject to frequent urination...……..		
Often thirsty…….……....		
Subject to prolonged bleeding after injury or tooth extraction…..…..…		

HAVE YOU TAKEN ANY OF THE FOLLOWING WITHIN THE PAST YEAR:

Fosamax, Actonel, Boniva.…….		
Anticoagulants (blood thinners)…..…..….		
Cortisone or another steroid….....		

DO YOU HAVE TROUBLE SWALLOWING PILLS?

Please add anything you feel is important:_____

_____

Patient's or parent's signature:_____

Do not write in this area Dr: _____ ASA Category: _____ BP: _____/_____ P: _____ Temp_____

_____

_____

_____

_____

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Medications

Patient name: _____ Date: _____ Dr: _____

Name of Prescribed Medicine, Over the Counter Medicine, Herbal Medicine, Vitamin, or Street Drug	Dosage (mg)	How Often Is it Taken	Disease Being Treated or Reason For Taking	Prescribing Dr. or Self Prescribed

TEMP:

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBILITY PARTY: **DATE:**

PLEASE ANSWER "Y" OR "N" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS

Have you had a COVID-19 vaccination?
If yes, when, which one? _____ when? 1st _____ 2nd _____
If not, are you planning on getting a COVID-19 vaccination? **Y/N**

Have you been diagnosed positive for the COVID-19 virus at any time? **Y/N**

Are you currently awaiting the results of a COVID-19 test? **Y/N**

Have you been exposed to anyone who has been diagnosed with COVID-19 in the past 21 days? **Y/N**

Have you experienced fever, headaches, fatigue, or weakness? **Y/N**

Have you lost your sense of taste and/or smell? **Y/N**

Do you have any shortness of breath, dry cough, or a sore throat? **Y/N**

Do you have sneezing, watery eyes, runny nose, and/or sinus pain/pressure that's not related to seasonal allergies? **Y/N**

Within the last 10 days, have you traveled within the United States or to any foreign country? **Y/N**

If so, where?

_____

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PATIENT INFORMATION

Today's Date: _____

NAME_____ HOME PHONE_____ WORK PHONE_____

EMAIL_____ CELL PHONE_____

HOME ADDRESS_____ CITY_____ ZIP CODE_____

SOC. SECURITY#_____ DATE OF BIRTH_____ AGE_____

PLACE OF EMPLOYMENT_____ OCCUPATION_____

SPOUSE/PARENT NAME_____ WORK PHONE_____

SPOUSE/PARENT PLACE OF EMPLOYMENT_____ SS #_____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? _____ PHONE_____

PRIMARY CARE PHYSICIAN_____ PHONE_____

PHYSICIAN SPECIALIST_____ PHONE _____

GENERAL DENTIST_____ PHONE_____

DENTAL SPECIALIST _____ PHONE _____

HOW DID YOU HEAR ABOUT OUR OFFICE OR WHO REFERRED YOU? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?_____

DO YOU HAVE DENTAL INSURANCE? Yes_____ No_____

DENTAL HISTORY

Date of last dental cleaning and check-up_____

DO YOU:	**Yes**	**No**
Have pain in your mouth…….	_____	_____
Where_____		
Have frequent headaches……....	_____	_____
Have popping or clicking joints in front of your ears……..…	_____	_____
Have pain in the joints in front of your ears……..	_____	_____
Clench or grind your teeth (circle which)…..	_____	_____
Have frequent problems with bad breath…….	_____	_____
Wear oral appliances (denture, bite guard, retainer, snore appliance, etc.)….	_____	_____

ALSO:

When were you first told of your periodontal (gum) problems_____

Use tobacco products: which and how much?_____

_____

Drink alcohol: How much_____

HAVE YOU:	**Yes**	**No**
Had gum surgery……	_____	_____
Had periodontal scaling (deep cleaning)……	_____	_____
Noticed bleeding gums when you brush…….	_____	_____
Had any teeth shift recently……...	_____	_____
Had orthodontics (braces)……..	_____	_____
Ever had a serious injury or blow to your mouth……..	_____	_____
Had your wisdom teeth removed……..…….	_____	_____

If yes, when_____

DENTAL CARE:

How often do you brush_____

How often do you floss_____

Which kind of toothbrush do you use_____

List any other oral hygiene products you use_____

_____

How often do you have dental cleanings and check-ups_____

Last Cleaning and Check-up:_____

Do not write in this area

_____

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