Patient Screening Form

Children's Dental Health Center, 966C Park Street, Stoughton MA 02072 (781)341-0030

Patient Name: ____________________DOB: __________ Cell #________________

(Day of Appt.)

	PRE-APPOINTMENT Date:		IN-OFFICE Date:
Do you/they have a 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 ae well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	_____YES _____NO		_____YES _____NO
Do you/they have heart disease, lung disease, kidney disease, diabetes or any other auto-immune disorders?	_____YES _____NO		_____YES _____NO
Have you/they traveled in the past 14 days to any regions affected by COVID-19 (or outside of MA)	_____YES _____NO		_____YES _____NO
TEMPERATURE			

Medical Updates & General Consent

DATE **CHANGES** **NO CHANGES**_________

_____ ____

____

____ Parent's Signature Reviewed By

____ _____________ ________

I consent to the following procedures today, which may be subject to change:

_______Exam/Prophylaxis _______Fluoride Varnish ______X-Rays

_______Sealants/Fillings/SSC/Pulpotomy/Extractions/Other: ____________________

________________________ ______________________

Parents' Signature Reviewed by

HIPAA Acknowledgement

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Children's Dental Health Center's Notice of Privacy Practices. By signing below, I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____________________________ _________________________

PATIENT NAME (Type or Print) **PARENT SIGNATURE** **DATE**

INSURANCE & PAYMENT POLICY

PRIMARY

Subscriber Name________________________

Insurance Co ___________________________

Member Number________________________

Employer ______________________________

SECONDARY

Subscriber Name __________________________

Insurance Co ____________________________

Member Number _________________________

Employer _______________________________

I hereby authorize payment directly to Children's Dental Health Center.

Payment/Co-Payment is due at time services are rendered.

Our office will submit insurance forms for you, however submission of forms is not a guarantee of payment. ***You, as Parent, are ultimately responsible for all treatment charges.***

___________________________________ _______________________________

Signature or Parent DATE Signature of Parent DATE