WESTSIDE DENTAL
162 W 72nd St, Suite #2
New York, NY 10023
Tel: (212) 496-2260
westsidedentalny@gmail.com

CORONAVIRUS SGREENING QUESTIONNAIRE

Date: Temperature:

Name:
First Last

Date of Birth: / / (MM/DD/YYYY)

Please circle Yes or No for the following questions:

1.	Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	YES	NO
2.	Are you/they having shortness of breath or other difficulties breathing?	YES	NO
3.	Do you/they have a cough?	YES	NO
4.	Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	YES	NO
5.	Have you/they experienced recent loss of taste or smell?	YES	NO
6.	Are you/they in contact with any confirmed COVID-19 positive patients?	YES	NO
7.	Is your/their age over 60?	YES	NO
8.	Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	YES	NO
9.	Have you/they been tested positive for COVID-19?	YES	NO
10.	Have you/they traveled in the past 14 days outside your/their state of residence?	YES	NO

Patients who are well but have a sick family member at home with COVID-19 should consider postponing/rescheduling elective treatment. Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with dental treatment.

Patient or Legal Guardian Signature

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PATIENT INFORMATION

Name: First Last Birthdate: MM/DD/YYYY Age:

Sex: ☐M ☐F ☐Other SSN: Driver's License No. and State:

Cell Phone #: Contact preferences (circle all that apply): Email Text Phone

Marital Status (circle one): Married Single Widowed Divorced Occupation:

Home Phone #: Work Phone #:

Email: Where did you hear about us:

Address: Street Apt #

City State Zip Code

Parent/Guardian Address:

Parent/Guardian Phone #: Email:

Emergency Contact Name: Phone #:

Relationship to Patient: Email:

INSURANCE INFORMATION

Insurance Company: Phone #:

ID #: Group #:

Subscriber Name (if different from patient):

Subscriber Birthdate: SSN/Member ID:

Relationship of Patient to Subscriber:

COMMUNICATION AND RELEASE

I hereby authorize and request any exam, x-rays, or diagnostic aids deemed necessary to make a thorough diagnosis. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as necessary. I agree to the use of anesthetics, sedatives, and other medications as necessary and understand that using these embody certain risks.

I acknowledge that I have reviewed the Notice of Privacy Policies, can get a copy upon request, and consent to the use of my Personal Health Information for the purposes of healthcare operations, treatment, and payment activities. I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment. I understand if I miss or cancel an appointment with less than 48hour notice, there will be a failed appointment fee of $50/hour booked, which I agree to pay before any further appointments can be made.

I have read and agree to the content, terms, and conditions listed above.

Patient or Legal Representative Signature Date

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MEDICAL HISTORY

Height: _____ Weight: _____

Are you currently under a physician's care?	☐ Yes ☐ No	If yes, with who and why?
Are you taking any medication, pills, or drugs?	☐ Yes ☐ No	If yes, please list them:
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, please explain:
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes, please explain:
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes, please explain:
Are you on a special diet?	☐ Yes ☐ No	If yes, please explain:
Do you use tobacco?	☐ Yes ☐ No	
Do you drink alcohol?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	
Have you traveled outside the U.S. in the last 30 days?	☐ Yes ☐ No	If yes, where?

Women: Are you….

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptive?

Please list any drugs, medications, or vitamins you are currently taking: _____

Please list any allergic reactions to an anesthetic or drug such as **penicillin, sedatives, latex, aspirin, or metals**: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Oral Herpes ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No

Do you have, or have you ever had, any serious illness not listed? If yes, please explain:

DENTAL HISTORY

Previous Dentist Name:

Date of Last Dental Exam:

Date of Last X-rays:

Date of Last Cleaning:

What is your reason for today's visit?

How did you hear about us?

Is there anything you would like to change about your teeth/smile?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient or Legal Representative Signature Date

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COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK

Print Patient's Full Name Date of Birth

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures can create fine water spray or "aerosols," which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

Patient Acknowledgement

I acknowledge that I have read the notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, receive exposure to COVID-19 from outside this office and unrelated to my visit here.

I have read and understood the information stated above:

Patient or Legal Representative Signature Date

If this Notice is signed by a personal representative on behalf of the patient, complete the following:

Print Legal Representative Name Relationship to Patient

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CONSENT FORM

Print Patient's Full Name _____ Date of Birth _____

I hereby authorize _____
Doctor's name

And whomever he/she may designate as his/her assistants, to perform upon me the following operation and/or procedures: Dentistry

I request and authorize him/her to do whatever he/she deems advisable if an unforeseen condition arises in the course of these designated operations and/or procedures, calling in their judgment for the procedures in addition to or different from those now contemplated.

I consent to the above treatment after having been advised of the risks, advantages, disadvantages of the treatment, and consequences if this treatment was withheld.

I consent to the above treatment plan after having been advised of the alternative plans of treatment available and the known material risks, advantages, and disadvantages of the alternative treatment.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case and understand that there is a slight element risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, aspiration, thrombophlebitis (e.g., irritation or swelling of the vein), pain, discoloration, and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include postoperative bleeding, swelling or bruising, discomfort, stiff jaw, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw, which might require extensive surgery removal.

I realize that despite the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science, and I acknowledge that there are no guarantees that have been made to me concerning the results of the operation or procedure.

I have provided as accurate and complete medical and personal history as possible, including those antibiotics, drugs, medications, and foods to which I am allergic. I will follow any and all instructions as explained and directed to me and permit prescribed diagnostic procedures.

I have had the opportunity to ask questions; receive answers to and get responsive explanations for all questions about my medical condition; and contemplate an alternative treatment, protocol, risk, and potential complications of the contemplated and alternative treatment and procedures prior to signing this form.

Patient or Legal Guardian Signature _____ Date _____

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FINANCIAL AND INSURANCE

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at the time of service. I understand any treatment fee will be honored up to 90 days from the date of examination. I understand, in order to collect any debt, my credit history may be checked through the use of my social security number and any other information given.

I understand that there is a $25 monthly late fee if I do not pay my balance within 30 days of a statement due date. There is a $35 processing charge for non-sufficient funds or returned checks. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in the collection.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize the release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

I understand this office will always do the best to help me maximize my dental benefits; however, the ultimate responsibility for payment is mine; and I am obligated and agree to pay this office in accordance with its credit terms and policy.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

☐ **I do not agree to the content above and/or do not want to disclose my SSN.** I realize this is my choice, and I can still get treatment here. I do understand this comes with the following changes: 1) all treatment will need to be paid in full at time of service, 2) insurance will reimburse me and not my dentist, 3) I must pay with a credit card or cash, 4) no payment arrangements will be possible, and 5) often insurance cannot be verified and estimates will be less accurate.

_____

Patient/Parent/Guardian Signature (Responsible Party) Date

_____

Relationship to Patient

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GENERAL DENTISTRY INFORMATION CONSENT

Print Patient's Full Name Date

Place your initials on each paragraph after reading. If you have any questions, please ask your doctor BEFORE placing your initials.

1. **I understand that I am having the following done:**
   X-Ray(s) &/or Exam Prophylaxis (Cleaning), Filling(s), Root Canal(s), Periodontal Treatment, Crown(s), Bridge(s), Dentures, Extraction(s)

   Initials: _____

2. **Drugs and Medications:**
   I understand that antibiotics, anesthetics, analgesics, and other medications can produce allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. Some medication that I might be currently taking could produce undesired effects or interfere with the normal process of healing (for example, aspirin could produce excessive bleeding during extraction, etc.) I understand that filling the health questionnaire out to the best of my knowledge is important in order to be prepared for any recommended procedure.

   Initials: _____

3. **Administration of Local Anesthesia:**
   I understand that there is always a slight risk of injury to the nerves during an injection. This may result in numbness or tingling of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side. This may persist for several weeks, months, or in extremely remote instances, may be permanent. Localized damage may also occur to some of the small blood vessels located in the area of the injection. This may result in swelling and/or bruising in the area. This usually subsides in 7-10 days without further symptoms.

   Initials: _____

4. **Changes in Treatment Plan:**
   I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination; for example, root canal therapy following routine restorative procedures or extraction of a tooth previously treated with root canal treatment. The dentist will explain all changes.

   Initials: _____

5. **Fillings:**
   I understand that care must be exercised in chewing on fillings, especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after-effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the fillings being done. I understand that sometimes it is not possible to match the color of natural teeth exactly with white fillings, especially when replacing existing metal fillings.

   Initials: _____

6. **Endodontic Treatment (Root canal):**
   I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend beyond the root, which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments, and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost, despite all efforts to save it.

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Initials: _____

7. Periodontal Treatment:

I understand that I have a serious condition, causing gum and bone inflammation that can lead to the loss of teeth. Alternative treatment plans have been explained to me, including deep cleaning, gum surgery, locally administered antibiotics, bone replacement, and/or extractions. I also understand that the success of the periodontal treatment depends not only on the procedure performed but also on the daily personal (brushing and flossing).

Initials: _____

8. Crowns, Bridges, Caps, and Implant Restorations:

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily, and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may cause tooth movement or recurrent decay. This may necessitate a remake of the crown, bridge, or cap. I understand that a root canal may be needed, even though the tooth may have not hurt prior to the crown or bridge having been done. I understand there will be additional charges for remakes due to my delaying permanent cementation. I understand that the remaking of the existing crown or bridge implies certain risks like pulp involvement, fracture of the root, etc., that could lead to further unexpected procedures.

Initials: _____

9. Dentures (Full or Partial):

I understand that wearing dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems with new dentures. The ability to adapt to removable dentures varies widely. In some cases, a patient cannot or will not be able to use the device through no fault of fabrication. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be an additional charge.

Initials: _____

10. Extraction of Teeth:

Alternatives, benefits, and consequences to the removal of the teeth (root canal therapy, crowns, and periodontal surgery, etc.) have been explained to me. I authorize the dentist to extract the following tooth (teeth) #'s _____. If any other extractions are necessary, the dentist will explain them according to paragraph #4 before the procedure. I understand extracting teeth may not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth extracted, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand that I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Initials: _____

I understand that dentistry is not an exact science and, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that regardless of any dental insurance coverage I may have, I am responsible for the payment of dental fees. I agree to pay attorney fees, collection fees, or court costs that may be incurred to satisfy this obligation.

_____

Patient or Legal Representative Signature Date

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