truForm by PBHS

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Covid-19 Questionnaire | Demographic Information | Insurance Information | Dental Information | Medical History | Medications / Allergies | Conclusion

Covid-19 Questionnaire

Patient Disclosures

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

Do you have a fever or above normal temperature? Yes No

Have you experienced shortness of breath or had trouble breathing? Yes No

Do you have a dry cough? Yes No

Do you have a runny nose? Yes No

Have you recently lost or had a reduction in your sense of smell or taste? Yes No

Do you have a sore throat?

Complete and Send ›

Yes No

Yes No

Date of Test

Positive Negative Awaiting Results

Yes No

Yes No

Yes No

Date of single dose vaccination

Date of 1st vaccination

Date of 2nd vaccination

Date of vaccination

Click to Sign

Date: ------------

COVID-19 Pandemic Dental Treatment Notice and Acknowledgement of Risk Form

Click to Sign

Date: ------------

Patient Information

Mr. Mrs. Ms. Dr.

Female Male

First Name	M.I.	Last Name	Nickname

Birth Date	Age	Social Security Number

Email

Street Address	Apt.	City	State	Zip (Postal Code)

Home Phone	Mobile Phone

Yes No

Yes No

First Name	Last Name

First Name	Last Name

Pharmacy Name	Pharmacy Phone Number

Yes No

First Name	Last Name

Section Two

Drivers License Number

First Name	Last Name	Phone Number

Employer Name	Business Phone

Cash Check Credit Card

In case of emergency

Emergency Contact Full Name

Home Phone	Relation to Patient

General Insurance Information

Full Time | Part Time | Retired | Not

Yes | No

Married | Divorced | Widow | Single | Legally Separated

Father | Mother | Self | Spouse | Other | Other Description

Who will be responsible for your account

First Name | Last Name | Social Security Number

Birth Date | Age

Home Phone | Drivers License Number

Street | Apt. | City | State | Zip (Postal Code)

Employer Name | Business Phone

Spouse or other guarantor information (if different from above)

First Name | Last Name | Relation

Birth Date | Social Security Number

Street | Apt. | City | State | Zip (Postal Code)

Employer Name | Home Phone | Business Phone

Full-time Part-time Not a student

Primary Insurance Information

Dental Medical

Employer / Business Name

Street Address

City | State | Zip (Postal Code)

Business Phone

Plan Name

Insurance Company Name

Insurance Policy I.D. Number

Insurance Company Address

City | State | Zip (Postal Code)

Insurance Company Phone

Group Number | Group Name

First Name | Last Name

Relation to Patient | Birth Date

Male Female

Street Address

City | State | Zip (Postal Code)

Insured Party Phone | SSN

Secondary Insurance Information

Dental Medical

Employer / Business Name

Street Address

City | State | Zip (Postal Code)

Business Phone

Plan Name

Insurance Company Name

Insurance Policy I.D. Number

Insurance Company Address

City | State | Zip (Postal Code)

Insurance Company Phone

Group Number | Group Name

First Name | Last Name

Relation to Patient | Birth Date

Male Female

Street Address

City | State | Zip (Postal Code)

Insured Party Phone | SSN

Dental Information

Reason for Visit

Yes No

In pain, for how long?

Please indicate any of the following problems by clicking "yes" on the corresponding question

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Please Describe

Last dental exam

Last dental x-rays

Times a day you brush?

Times a week you floss?

1 2 3 4 5 6 7 8 9 10

Yes No

Soft Medium Hard

Medical History

Yes No

Height

Weight

Yes No

Yes No

Yes No

Yes No

Yes No

Have you had or do you currently have...

Yes No

Yes No

Yes No

Have you had or do you currently have...

Yes No

Yes No

Yes No

Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No

Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
If so, how much a day
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Are you now taking:

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Are you allergic or had a reaction to:

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Please list

Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic name

Medication / Antibiotic name

Medication / Antibiotic name

Medication / Antibiotic name

Medication / Antibiotic name

Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic name

Medication / Antibiotic name

Medication / Antibiotic name

Medication / Antibiotic name

Medication / Antibiotic name

Verification

Yes No

Click to Sign

Date: ------------

Click to Sign

Date: ------------

Click to Sign

Date: ------------

Click to Sign

Date: ------------