Health History Update

Name_____ Email Address _____

SINCE YOUR LAST VISIT: has any of the following information changed? If so, please list:

1. Address: _____
2. Phone Number: _____ Work Phone Number: _____Cell Phone #_____
3. Insurance Company: _____ 4. Employer: _____

SINCE YOUR LAST VISIT:			Describe
1. Have you been a patient in a hospital?		Yes___ No ___	_____
2. Have you been under the care of a physician?		Yes___ No ___	_____
3. Has your health changed?		Yes___ No ___	_____
4. WOMEN:	Are you pregnant?	Yes___ No ___	
	Are you nursing?	Yes___ No ___	

CIRCLE ANY OF THE FOLLOWING YOU HAVE EVER HAD:

alcoholism	drug addiction	HIV/AIDS	seizures
anemia	emphysema	joint replacement	sinus problems
angina	excessive bleeding	kidney problem	stomach problems
asthma	glaucoma	liver problem	stroke
blood problem	heart murmur	lung disease	surgery_____
cancer	heart problems	mitral valve prolapse	surgical pins/plates
chemotherapy	heart surgery	osteoporosis	thyroid problem
cold sores	heart valve problem	pacemaker	tuberculosis
congenital heart problem	hepatitis	psychiatric treatment	ulcers
diabetes	herpes	radiation therapy	other_____
dizziness/fainting	high blood pressure	rheumatic fever	

1. List all current medications (including vitamins, birth control pills and pain relievers): _____
   _____
2. List any allergies_____
3. Physician's name:_____ Date of last exam:_____

I certify that the above is correct to the best of my knowledge. I will not hold the dentists or their staff responsible for errors or omissions that I may have made in the completion of this form.

I understand that I am financially responsible for all costs of dental treatment, including any charges not covered or paid for by my insurance company, or any additional dentistry that may be necessary during treatment. I also understand that unless I give 24 hrs. notice, I will be charged $50 per half-hour for an appointment that is not kept. I authorize release (including electronic) of any information relating to treatment. I understand that the information will be sent either by mail or in unencrypted electronic form and there is some risk that third parties might be able to access this data. I hereby assign payment of my insurance company benefits otherwise payable to me directly to John L. Little, D.D.S., P.A.

PATIENT_____ DENTIST Sig_____

GUARDIAN_____ WITNESS _____

DATE _____

DENTAL VISIT COVID INTRUCTIONS/CONSENT

Prior to Arrival

1. In order to protect you and our staff, please fill out and send us any forms we send you. We understand this process may be tedious, but the information is required by various government agencies for patient and staff protection.

2. If for some reason, you can't fill out a form, call us and we will verbally review the forms with you.

3. Patients must fill out a new COVID screening form prior to every visit. If the form indicates that you (your child) is at risk of having COVID, we will ask you to cancel your appointment.

Arrival

Please arrive 5 minutes prior to your scheduled visit. When you arrive for your visit, stay in your car and call our office for check-in instructions. You may be asked some health questions. (732) 449-6564.

Masks/Warm Clothes

Please wear a mask at all times except when the Dentist advises you to remove it. If you do not have a mask we will provide it at check-in. All office windows will be open, so please dress in layers or bring something to keep you warm if it is cold outside.

Guardians

There is a limit of one guardian for children under 18 or patients who need assistance. Guardians must wear masks and are asked to return to their cars while the patient is being treated. We will call you when the patient is finished.

Patients with Dental Insurance

Those patients who have been furloughed or lost employment will be fully responsible for verifying existing coverage. Our office will make every effort to help patients, however, lapses in coverage may not recorded by the insurance company until after a date of service. Patients are responsible for any dental fees not covered by insurance.

Hand hygiene protocol

Alcohol hand sanitizer is located throughout the office and patients are encouraged to use as needed.

CDC/OSHA/Government Infection Control

As in the past, our office meets or exceeds all infection control protocols to limit transmission of all diseases, including COVID-19 virus. We have also implemented many new protocols. Our staff is symptom-free, undergoes COVID screening every day, and, to the best of their knowledge, have not been exposed to the virus. Our protocols also include as much social distancing as practical.

Informed Consent for Dental Visit

Our office is committed to reduce the risks of disease transmission. Despite this, due to the nature of viruses, there is still a chance that you (your child) could be exposed to a virus in our office, just as you (your child) might be at another public place.

I understand and agree to the statements in this document; I also accept the risks and consent to dental treatment.

_____ _____

PATIENT/REPSONSIBLE PARTY **DATE**

COVID Advisory and Screening Form

Patient name _____

Our office complies with the State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus. Our staff is 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 have 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.

FOR YOURSELF/CHILD PLEASE ANSWER " YES" OR " NO" TO THE FOLLOWING QUESTIONS:

TODAY AND IN THE PAST 14 DAYS--

DO YOU HAVE/HAD A FEVER?	**YES**	**NO**
DO YOU HAVE/HAD ANY SHORTNESS OF BREATH OR DIFFICULTIES BREATHING?	**YES**	**NO**
DO YOU HAVE/HAD A DRY COUGH OR SORE THROAT?	**YES**	**NO**
DO YOU HAVE/HAD FATIGUE OR STOMACH UPSET OT HEADACHE?	**YES**	**NO**
DO YOU HAVE/HAD LOSS OF TASTE OR SMELL?	**YES**	**NO**
WITHIN THE LAST 14 DAYS, BEEN AT A GATHERING OF 10 OR MORE PEOPLE?	**YES**	**NO**
HAVE YOU HAD COVID 19 or CLOSE CONTACT WITH ANYONE WHO HAS BEEN DIAGNOSED WITH COVID 19 OR SUSPECTED TO BE POSITIVE FOR COVID 19 ?	**YES**	**NO**
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED OUTSIDE MONMOUTH OR OCEAN COUNTIES?	**YES**	**NO**

IF SO, WHERE?

_____ _____

PATIENT/RESPONSIBLE PARTY **DATE**

_____

REVIEWED BY