ADA American Dental Association®
America's leading advocate for oral health

Patient Name: _____

Patient Screening Form

	PRE-APPOINTMENT	IN-OFFICE
Please use an "X" to mark your answers to the following questions.	Date:_____/_____/_____	Date:_____/_____/_____
1. Do you/the patient have fever or have you/the patient felt hot or feverish recently (14–21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you/the patient having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you/the patient have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
4. Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you/the patient experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
6. Are you/the patient in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
7. Is your/the patient's age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
8. Do you/the patient have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you/the patient traveled in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

For testing, see the Centers for Disease Control and Prevention (CDC)'s list of State and Territorial Health Department Websites for your specific area's information: **https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html**.

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Today's Date: _____

Child's Dental & Medical Health History Information

To the parents/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

PATIENT INFORMATION

Last Name: First Name: Middle Name: Nickname:

Date of Birth: / / Gender:

Parent's/Guardian's Name: Relationship to Patient:

Email Address:

Home Phone: Cell Phone: Work Phone:

Mailing Address: City: State: Zip:

Please use an "X" to mark your answers to the following question.

Have you (the adult) or the patient (the child) had? ☐ A cough that's lasted longer than three weeks ☐ A cough that produces blood ☐ Active Tuberculosis

Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

PATIENT'S DENTAL HEALTH HISTORY

What is the reason for your visit today?

How would you describe the patient's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the patient currently have any dental pain or discomfort? ☐ Yes ☐ No If yes, where? _____

Is this the patient's first visit to a dentist? ☐ Yes ☐ No
If no, when was the patient's last dental exam? _____ What was done at that appointment? _____

When was the last time the patient had dental x-rays taken?

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**	**?**
Has the patient had any problem with dental treatment in the past? If yes, please describe what happened: _____	☐	☐	☐
Has the patient had any problems with teeth coming in or losing teeth?	☐	☐	☐
Does the patient use fluoride toothpaste when brushing teeth? How often are the patient's teeth brushed? _____ time(s) per _____ At what time(s) of day are the teeth brushed? _____	☐	☐	☐
Has the patient ever worn braces or other orthodontic appliances?	☐	☐	☐
Has the patient ever had a serious injury to the head, mouth or teeth? If yes, please describe what happened and when it happened: _____	☐	☐	☐
Does the patient play any contact sports or participate in active recreational activities? If yes, please describe those activities here: _____	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
What is the patient's primary source of drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Well			
Does the patient take fluoride supplements?	☐	☐	☐
Does/did the patient use a pacifier or suck his/her thumb or fingers? At what age did the patient stop breastfeeding? _____ At what age did the patient stop bottle feeding? _____	☐	☐	☐
Has the patient ever experienced any sleep-related breathing disorders? ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep			

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PATIENT'S MEDICAL HEALTH HISTORY & VACCINATION STATUS

Please list the name and phone number of the patient's physician:

Doctor's Name: _____ Phone: _____

Does the patient see any medical specialists? ☐ Yes ☐ No If yes, please explain. _____

Please use an "X" to mark your answers to the following questions.	Yes	No	?	
Is the patient currently being treated for any condition(s) or illness(es)?	☐	☐	☐	If yes, what is the illness and when did it start?
Has the patient ever had a serious illness?	☐	☐	☐	If yes, what was the illness and when did it happen?
Has the patient ever been hospitalized?	☐	☐	☐	When and why?
Has the patient ever been given a general anesthetic?	☐	☐	☐	
Has the patient ever had a blood transfusion?	☐	☐	☐	
Does the patient experience excessive bleeding when cut?	☐	☐	☐	
Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist?	☐	☐	☐	If so, please explain why and provide the name of the doctor making that recommendation. Doctor's Name: _____ Phone: _____
Has the patient been diagnosed with any physical, developmental, mental or emotional conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any genetic (inherited) conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any speech difficulties?	☐	☐	☐	If yes, please explain.

How would you describe the patient's eating habits?

Is the patient up-to-date with immunizations related to patienthood diseases (tetanus, measles, mumps, etc.)? ☐ Yes ☐ No

If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? ☐ Immunized ☐ Not immunized

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

- ☐ ADD/ADHD
- ☐ Alcohol/Drugs
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder problems
- ☐ Bleeding disorders
- ☐ Bone/Joint issues
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic sinusitis
- ☐ Diabetes
- ☐ Ear aches
- ☐ Epilepsy
- ☐ Fainting
- ☐ Growth problems
- ☐ Hearing problems
- ☐ Heart Issue
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Immunizations
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pregnancy (teens)
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually transmitted infection (STI)
- ☐ Sickle Cell Anemia
- ☐ Thyroid issues
- ☐ Tobacco/Vaping
- ☐ Tuberculosis
- ☐ Other: _____

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications? If yes, please list them here: _____	☐	☐	☐
Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications? If yes, please list those medications and what happened when the patient took them: _____	☐	☐	☐
Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.? If yes, please describe the allergy and the reaction: _____	☐	☐	☐

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The dentist and I have talked about any questions I had about this form.

I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Parent/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only:

☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

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