**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by: **Mom / Dad / Patient  / Other**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID-19 SCREENING QUESTIONS:**

1. Has the patient or anyone in contact with the patient experienced signs or symptoms of COVID-19 in the past 21 days such as cough, fever, difficulty breathing, sore throat, nausea, fatigue, headache, runny nose or loss of taste and/or smell? **YES | NO**

 If yes, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Has the patient or anyone in contact with the patient traveled outside of the country in the past 21 days?

 **YES | NO**

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Has the patient, caregiver, or other household member been tested for COVID-19 in the past 21 days?

 **YES | NO**

If yes, what was the result? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Has the patient or caregiver come in contact with a person who is COVID-19 positive or a person who has suspected exposure to COVID-19 in the past 21 days?  **YES | NO**

**COVID-19 CONSENT FOR TREATMENT:**

1. As the parent/legal guardian or patient, I consent to dental treatment during the COVID-19 pandemic **YES | NO**

2. As the parent/legal guardian or patient, I consent to comply with the new office COVID-19 policies (listed at happykidssmiles.com) **YES | NO**

**UPDATED MEDICAL HISTORY**

1. Are there any updates to your child’s medical history, such as new allergies, medications, medical diagnoses, or hospitalizations? **YES | NO**

If yes, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*IF APPLICABLE\* UPDATED CONTACT, MAILING, and EMPLOYER INFORMATION**

1. Has your contact information changed since your last visit? **YES | NO**

Updated parent/guardian cellphone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Updated parent/guardian home phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Updated parent/guardian email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Has your family moved since your last visit? **YES | NO**

 Updated mailing address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you have well water at your new home? **YES | NO**

2. Have you changed jobs since your last visit? **YES | NO**

New employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 New work phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you have new dental insurance? **YES | NO**

 \*If yes, we will need a copy of your new insurance card

**\*OPTIONAL\***

We care! Please brag about your child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Parent/Legal Guardian**

**Or Patient Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_