

**Spangler, Rohlfing & Lambert Pediatric Dentistry
COVID-19 Screening and Patient Update Form**

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

**Parent/Legal Guardian
Or Patient Signature** _____

Date _____