

UPDATE HEALTH / PERSONAL/COVID INFO FORM

(Must Be Completed Every Visit)

Patient Name: _____	Phone: _____
Email: _____	
Is there any change in Address?	<input type="radio"/> Yes <input type="radio"/> No
If Yes: _____	
Is there any change in Phone Number?	<input type="radio"/> Yes <input type="radio"/> No
If Yes: _____	
Is there any change in Dental Insurance?	<input type="radio"/> Yes <input type="radio"/> No
If Yes: _____	
Is there any changes in Medical History?	<input type="radio"/> Yes <input type="radio"/> No
If Yes: _____	
Is there any new Medication Started?	<input type="radio"/> Yes <input type="radio"/> No
If Yes: _____	
Any Covid-19 symptoms? <input type="checkbox"/> Fever <input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose <input type="checkbox"/> Head ache <input type="checkbox"/> Muscle Pain	
Is there any changes in Covid-19 history since your last dental visit 2022?	<input type="radio"/> Yes <input type="radio"/> No
If Yes: _____	