North Point Dental Associates

www.northpointsmiles.com

6425 Old Plank Rd | Suite 102 • High Point, NC 27265 (336)886-1747

Health History Update

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ ____________________ ____ ____________________
Last First MI Preferred Name

Title: ____________ Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______________

SS#: ___-__-____

Prev. Visit: ______________

Email Address: ____

Best time to call: ____________________

Phone: ____________ ____________ ____________ ______ ____________ ____________
Home Mobile Work Ext Fax Other

Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ________ _____-____
City State Zip Code

In an emergency who should be notified? Please enter Name and Phone number below:

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Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ AIDS/HIV
☐ Allergies	☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro
☐ Allergy - Hay Fever	☐ Allergy - Iodine	☐ Allergy - Latex	☐ Allergy - Other
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Allergy-Barbiturates	☐ Anemia
☐ Arthristis, Rheumati	☐ Artificial Joints	☐ Asthma	☐ Back Problems
☐ Bleeding Abnormally	☐ Blood Disease	☐ Cancer	☐ Chemical Dependency
☐ Chemotherapy	☐ Circulatory Problems	☐ Congenital Heart Les	☐ Cortisone Treatments
☐ Cough, persistent	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Fainting or Dizzines	☐ Headaches	☐ Heart Murmur	☐ Heart Problems
☐ Hepatitis Type	☐ Herpes	☐ High Blood Pressure	☐ Jaw Pain
☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure	☐ Mitral Valve Prolaps
☐ Nervous Problems	☐ Pacemaker	☐ Psychiatric Care	☐ Radiation Treatment
☐ Respiratory Disease	☐ Rheumatic Fever	☐ Scarlet Fever	☐ SEE LIST OF MEDS
☐ SEE MEDICAL HISTORY	☐ Shortness of Breath	☐ Sinus Trouble	☐ Skin Rash
☐ Special Diet	☐ Stroke	☐ Swollen Feet or ankl	☐ Swollen Neck Glands
☐ Thyroid Problems	☐ Tonsillitis	☐ Tuberculosis	☐ Tumor or growth

☐ Ever been hospitalized (illness or injury)	☐ Presently being treated for any other illnesses
☐ Taking medication for weight control (ie fen-phen)	☐ Taking dietary supplements
☐ Subject to frequent headaches	☐ A smoker or smoked previously
☐ FEMALE: Taking birth control pills	☐ FEMALE: Pregnant

Do you take antibiotic premedication for your dental visits? If yes, please explain.

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Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

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☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

COVID-19

Do you/they have a fever or you/they felt hot or feverish recently (14-21) days?
* ◯ Yes ◯ No

Are you/they having shortness of breath or other difficulties breathing?
* ◯ Yes ◯ No

Any flu-like symptoms, such as gastrointestinal upset, headache or fatigue?
* ◯ Yes ◯ No

Do you currently have a cough? * ◯ Yes ◯ No

Have you/they experienced recent loss of taste or smell? * ◯ Yes ◯ No

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Are you/they in contact with any confirmed COVID-19 individual, OR in contact with someone experiencing symptoms? * ◯ Yes ◯ No

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Have you/they traveled in the past 14 days by air, bus, or train?
* ◯ Yes ◯ No

Have you been tested for COVID-19 in the LAST 21 days? * ◯ Yes ◯ No

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I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate. *
◯ Yes ◯ No

COVID-19 NOTICE AND ACKNOWLEDGEMENT OF RISK

☐ ***Our goal at North Point Dental Associates is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.**

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

COVID-19 has a long incubation period. You or all your health care providers may have the virus and not show symptoms and yet still be highly contagious. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus by simply being in a dental office.

Dental procedures create water spray which is one of the ways the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the notice above and understand and accept that there is an increased risk of contracting COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract COVID-19 virus from outside this office and unrelated to my visit here.

I have read and fully understand the information stated above. ○ Yes ○ No

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Response Date: ____________