Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they 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
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ 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 list of State and Territorial Health Department Websites for your specific area's information.

PATIENT INFORMATION UPDATE

WILLIAM J FESSLER FAMILY DENTISTRY

READ AND ANSWER ENTIRE PAGE PLEASE

Patient Name _____ Birth date _____ Soc.Sec._____

Address : _____ City _____ State _____ Zipcode _____ Occupation: _____

Cell Phone Number: _____ Email Address: _____ *May we text/email you? Y or N

Employer:_____ Phone: _____ Address _____

**Has there been a change of DENTAL Insurance Carrier? Y or N

If YES please provide new information:

***PRIMARY* DENTAL INSURANCE INFORMATION**

Subscriber_____ Date of Birth_____ Soc. Sec._____

Employer_____ Relationship to Pt_____

Insurance Company full Name_____ Ins Co. address_____

Insurance Company Phone _____

Group ID#_____ Patient ID #_____

***SECONDARY* DENTAL INSURANCE INFORMATION**

Subscriber_____ Date of Birth_____ Soc. Sec._____

Employer_____ Relationship to Pt_____

Insurance Company full Name_____ Ins Co. address_____

Insurance Company Phone _____

Group ID#_____ Patient ID #_____

*Has there been a change in Health History since your last visit? Y / N

If Yes please provide new information:_____

(Surgeries/replacements)_____

(Medications)_____

(Allergies)_____

*Has there been a change in Dental History since your last visit? Y / N

If Yes please provide new information: _____

_____

Assignment and Release

William J Fessler Family Dentistry requires payment at time of service. If you choose to discontinue care before treatment is complete, you will only be charged for care received. We submit to insurance as a courtesy. Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, coinsurance, or any other balance not paid by your insurance at time of service. If our office is unable to collect payment from your carrier due to insufficient subscriber information, or denial of benefits, the patient is responsible for balance on account. The patient and or responsible party agree to pay INTEREST at the rate of 1 ½% per month and all costs of collection, including reasonable attorney fees, on all amounts due on account more than 30 days from the date of service. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I further hereby assign all dental benefits, to which I am entitled, including private insurance, and other health plans to William Fessler Family Dentistry. Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I further give permission to pull a credit report as needed, should my account be turned over to an outside source for a collection effort. A fee of $65. is charged for patients who miss or cancel an appointment more than 1 time in a calendar year without 24 hours notice. Current Bank Fees for NSF checks will be billed to the patient for any returned checks.

_____ _____

(Responsible Party Signature: Patient, Parent or Guardian Signature) (Date)

Click SUBMIT button to send your completed form to our office. This button only works in Acrobat.

If you are having trouble, you can send the form in an email to: admin@wfesslerdds.com

SUBMIT