PEDIATRIC DENTISTRY
Drs. Spangler, Lambert & Lipp
CREATING HAPPY KIDS' SMILES

Medical History Update and COVID-19 Screening Questionnaire

Patient Name: _____
Completed by: _____

Medical History Update

Please describe any changes to your child's medical history since their last visit

Is your child being treated by a physician at this time? ☐ YES ☐ NO
If yes, please describe reason _____

Does your child have any *newly* diagnosed medical conditions? ☐ YES ☐ NO
If yes, list condition(s) _____

Is your child taking any *new* medications, vitamins, or dietary supplements? ☐ YES ☐ NO
If yes, list name(s) and dosage(s) _____

Has your child had any *new* hospitalizations, surgeries, significant injuries, or illnesses? ☐ YES ☐ NO
If yes, please list date and describe: _____
_____

Does your child have any *new* allergies (ex: antibiotics, latex, anesthetic, metals, or dyes)? ☐ YES ☐ NO
If yes, please list and describe reaction: _____
_____

COVID-19 Screening Questions*:

Has the patient or anyone in contact with the patient experienced signs or symptoms of COVID-10 in the past 10 days (ex: cough, fever, difficulty breathing, sore throat, nausea, fatigue, headache, runny nose, or loss of taste/smell? ☐ YES ☐ NO
If yes, please list symptoms _____
Date symptoms began _____
Person(s) experiencing symptoms _____

Has the patient or household member come in contact with a person who is COVID-19 positive (or suspected COVID-19 positive) in the past 10 days? ☐ YES ☐ NO
Date of exposure _____

Has a patient or household member been tested for COVID-19 in the past 10 days? ☐ YES ☐ NO
If yes, what was the test result? _____
Date of test _____
Person(s) tested _____

*If you answered "YES" to any of the above questions, please call our office at (336)768-1332 (Winston-Salem) or (336)992-9222 (Kernersville) to confirm you are able to attend your scheduled appointment.

Demographic Information Update

Has your contact information changed since your last visit? ☐ YES ☐ NO

If yes, please list changes _____

_____

Has your family moved since your last visit? ☐ YES ☐ NO

Updated mailing address _____

_____

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

Have you changed jobs since your last visit? ☐ YES ☐ NO

If yes, please list new employer _____

Has your dental insurance changed since your last visit? ☐ YES ☐ NO

Updated Dental Insurance _____

Policy holder _____

Policy number _____ Group number _____

OPTIONAL

We care! Please brag about your child and new things going on in their life

_____

_____

_____ _____

(Patient or legal guardian signature) (Date)