STANFIELD DENTAL PLLC

PATIENT SCREENING FORM to be completed at each visit.

Patient Name_____

Phone #1_____Alt Phone # _____

Date_____ Emergency Contact_____

HIPPA Release for authorized representative:

Name/Tele/ relation and if there is to be an expiration date:_____

Answer the following questions YES or NO

Do you have a fever: or felt feverish in the last 14 days: _____

Do you have a cough:_____Any flu like Symptoms:_____

Have you been around anyone confirmed COVID-19 in the last week?_____

Patients with Covid-19 confirmed family members should consider postponing treatment.

Do you have heart disease, kidney disease, or any auto-immune disorders?_____

If required to medicate prior to dental services, did you do so prior to today treatment? _____

Health or Medical Changes Since last Update_____

Do you need a refill for future dental appointments?_____Please tell the doctor or assistant.

If applicable to stop/start any medications prior to dental treatment, did you remember to do so?_____

Has your dental insurance changed prior to your last visit with our office?_____

Changes to insurance is required prior to treatment, we will only bill the insurance on file at the time of treatment. Any insurance changes or additional insurance brought to our offices attention after todays services will be the patients billing responsibility.

Are you aware of the treatment you are scheduled for today? _____

Are you aware of the Estimated patient financial responsibility for today's services? _____

AS per the treatment plan, this is only an estimate until the services have been rendered and presented to your insurance company for review and payment. Today's treatment is ultimately the patient's financial responsibility.

Our office does offer 3rd party Financing please ask a team member if you are interested. Not all financing is available on the day of service. Thank you Stanfield Dental 623 939 5131

Patient Name_____Date_____