COVID-19 INTAKE FORM

Patient Temp Upon Arrival (Office Use Only):_____

PATIENT INFORMATION

Name: _____ DOB: _____ Age: _____ Sex: ☐ Male ☐ Female
First and Last

Phone#:_____ Email:_____ Address:_____

City: _____ State: _____ Zip-Code: _____ County:_____

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian Or Other Pacific Islander
- ☐ White
- ☐ Other Race

Ethnicity:

- ☐ Not of Hispanic, Latino or Spanish Origin
- ☐ Hispanic, Latino or Spanish Origin

SCREENING QUESTIONS

Have you experienced any of the following symptoms within the last 14-21 days?

- ☐ Fever or Chills (R50.9)
- ☐ Fatigue (R53.83)
- ☐ New loss of taste or smell (R43.9)
- ☐ Nausea (R11.0)
- ☐ Vomiting (R11.11)
- ☐ Cough (R05)
- ☐ Muscle or body aches (R52)
- ☐ Sore Throat (R07.0)
- ☐ Diarrhea (R19.7)
- ☐ Difficulty breathing (R06.0)
- ☐ Headache (R51.9)
- ☐ Congestion or runny nose (R09.81)
- ☐ Nausea w/vomiting (R11.2)

In the last 2 weeks, have you had any of the following exposures? (Select all that apply)

- ☐ International travel
- ☐ Suspect you've been exposed to COVID-19
- ☐ None of these
- ☐ Been in direct contact with any person(s) positive for COVID-19
- ☐ Live in or have visited an area where there has been community spread of COVID-19*

* Areas where people have been infected with the coronavirus, including some who are not sure how or where they become infected.

Do any of the following describe your work setting? (Select all that apply)

- ☐ Healthcare Facility: I work in a clinic, hospital, nursing home, or senior care facility or other healthcare facility
- ☐ First Responder: I am a first responder, such as an ambulance worker, law enforcement officer, or firefighter
- ☐ None of the above

PATIENT SIGNATURE

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and may still be highly contagious. It is impossible to determine with certainty, who has been infected or when it can be transmitted, even with COVID-19 testing. Dental procedures create water spray which is one way in which the disease may be spread. The ultra-fine nature of the spray can linger in the air from minutes to sometimes hours, which can possibly transmit the COVID-19 virus. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to not only myself, but other patients, providers and team members.

Patient Signature: _____ Date: _____

COVID-19 TESTING (Office Use Only)

☐ Testing recommended declined
☐ Proceed with treatment ☐ Postpone Treatment

☐ Testing **NOT** recommended
☐ Proceed with treatment ☐ Postpone Treatment & refer

Testing Recommended for:

- ☐ Asymptomatic Patient
- ☐ Symptomatic Patient (See Symptom Codes Above)
  - ☐ Known Exposure to COVID-19 **(Z20.828)**
  - ☐ Suspected Exposure to COVID-19 **(Z03.818)**
- ☐ Screening for COVID-19 **(Z11.59)**

☐ Completed 87426 - CareStart™ Rapid Covid-19 Antigen Test
☐ Patients results were negative for COVID-19. Proceed with treatment as scheduled.
☐ Patients results were Positive for COVID-19 **(B34.2)**
Dental treatment will be postponed. Patient was instructed to follow current CDC guidelines and consult their healthcare provider.

Medical Insurance: ☐ Yes ☐ No

Copy of Insurance Card: ☐ Front ☐ Back

Submitted to medical insurance: ☐ Yes ☐ No

Provider Information:

Name:_____ NPI: _____
First, Middle int and Last

Facility Name:_____ CLIA ID#:_____

Address:_____

City:_____ State: _____ Zip Code: _____

Phone:_____

STATE REPORTING REQ

Test Ordered: LOINIC Device ID:_____ Test Result: _____

Test Result Date: _____ Specimen ID:_____ Specimen Source :_____

Date Test Ordered: _____ Date Specimen Collected:_____

Reported to the State Agency: ☐ Yes Int: _____