Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )
Address: *Mailing address*
City: State: Zip:
Occupation:
Height: Weight: Date of Birth: Sex: M F
SS# or Patient ID: Emergency Contact: Relationship:
Home Phone: *Include area code* ( )
Cell Phone: *Include area code* ( )
If you are completing this form for another person, what is your relationship to that person?
Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? (*Check one:*) DAILY☐ / WEEKLY ☐ / OCCASIONALLY ☐			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?
Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )
Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?
Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

The Smile Spa
OF NORTH JERSEY, LLC

Dr. Debra Rosenblatt, DDS, FAGD

759 Lafayette Avenue, Suite A
Hawthorne, NJ 07506
phone 201-427-1443
fax 973-427-7112

251 Godwin Ave
Midland Park, NJ 07432
phone 201-445-2797
fax 201-445-8340

ABOUT YOU

Patient Name: _____ Male ____ Female ____ Today's Date: ___/___/___

What do you prefer to be called? _____ Referred by: _____

Occupation: _____

Employer: _____ How Long? _____

Employer's Address:

_____
(City) (State) (Zip Code)

Status (circle): Minor Single Married Divorced Separated Widowed

Spouse Name: _____

Do you have children? Yes No How many? ____

EMERGENCY CONTACT

Whom should we contact? _____ Relation: _____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

Who is your Medical Doctor? _____ Medical Doctor's Phone Number: (___)_____

ACCOUNT INFO: Person ultimately responsible for account

Name: _____ Relation: _____ SSN: _____

Billing Address: _____
(City) (State) (Zip Code)

Driver's License #: _____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

Payment Method (circle): Cash Check Credit Card

Credit Card: _____ Credit Card #: _____ Credit Card Exp. Date: ___/____

_____ (Initial) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this site).

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take X-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patient's dental needs. I also acknowledge that costs associated with certain procedures may not be covered by my insurance provider.

_____ (initial)

2. Upon such diagnosis, I authorize doctor or designated staff to perform all recommended treatment agreed upon by me and as required to provide proper care. I acknowledge that all costs associated with these procedures may not be covered by my insurance provider.

_____ (initial)

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

_____ (initial)

4. I agree to be responsible for payments of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service, unless other arrangements have been made. In the event payments are not received within 30 days, I understand that a 1.5% late charge (18% APR) plus a monthly billing charge of $2.50 will be added to my account.

_____ (initial)

5. A collection fee representing one-third of the outstanding balance will be added if the account is referred for collections to an outside company or attorney.

_____ (initial)

Patient: _____ Date: ___/___/___

Witness: _____

Parent or Guardian: _____

Relation to Patient _____

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INSURANCE INFO

Primary Dental Insurance:

Company Name: _____

Address:

_____

(City) (State) (Zip Code)

Phone: _____

Insurance ID #: _____ Group ID# (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____ DOB: ___/___/___

Insured's Employer: _____

Secondary Dental Insurance:

Company Name: _____

Address:

_____

(City) (State) (Zip Code)

Phone: (___)_____

Insurance ID #: _____ Group ID# (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____ DOB: ___/___/___

Insured's Employer: _____

UNDERSTANDING YOUR DENTAL INSURANCE

Dental Insurance is a contract between the Insured (patient) and their Insurance Provider. We are vending dentists with your plan and to insure a mutually beneficial long-term patient relationship; it is imperative that there is a clear understanding of your dental benefits for yourself and dependents.

Patient: _____

Insurance Company: _____

Primary: _____

Secondary: _____

1. I understand my insurance implicitly and consent to the dental treatment needed.

_____ (Patient Signature)

2. I need further clarification of my benefits from the insurance coordinator in this office.

_____ (Patient Signature)

3. I need to speak with human resources or my insurance company directly in order to understand my benefits and my individual monetary obligation and wish to hold off on any recommended treatment.

_____ (Patient Signature)

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FINANCIAL POLICY

Our office is committed to providing the best possible dental care for you. We pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have questions about our fees, our financial policy, or your financial responsibility.

PARTICIPATING INSURANCE PLANS
We require you to show your current insurance card at each office visit. If your insurance company does not respond to our claim's submission, we will submit the claim a second time. If they have failed to pay after the second submission the balance will become your responsibility and is due within 30 days of billing. You are responsible for any deductible and balance your insurance indicates in their explanation of benefits (EOB). These balances are due in full within 30 days of your first bill.

DIVORCE SITUATIONS
The parent who brings a child in for the visit is responsible for payment at the time of service regardless of the financial arrangements of the divorce. Our goal is to be able to provide the appropriate dental care for your child.

PATIENTS ACCOUNTS
You are responsible for timely payment of your account. Any patient balance left after 120 days without any attempts at resolution will be considered delinquent and may be submitted to a collection agency. If you are having financial hardship, please speak with the billing office and we will make every effort to set up an acceptable payment plan with you. If an account is turned over to collection, we will be unable to provide any further dental care. Submission to a collection agency could affect your credit rating.

We accept cash, personal checks, Visa/Mastercard, Discover and American Express.

_____
Initial

MISSED APPOINTMENT POLICY

I have been thoroughly informed that according to the agreement with my insurance company all appointments must be kept unless 24 hours' notice is given.

If for any reason I do not keep my appointment or cancel without 24 hours' notice, there will be a disappointment charge of $25 for General Dentist per each ¼ hour and $50 per each ¼ hour for Periodontist, unless mandated differently by your insurance company.
****NO INSURANCE COMPANY COVER BROKEN APPOINTMENT FEES UNDER ANY CIRCUMSTANCES!
****ALL MONDAY APPOINTMENTS THAT NEED TO BE CHANGED, MUST BE CHANGED ON THE FRIDAY PRIOR TO YOUR VISIT.

Duplication of X-Rays Policy
There will be a $30 duplication fee on each set of X-rays requested. In addition, the office will need a Written Authorization Release Form from the patient.

Co-Payment Policy
All co-payments are due at time of service. If co-payment is not paid at time of service, there will be a $10 surcharge added. Please send co-payments with any caretaker who brings your child to the office.

Patient Name: _____ Parent/Guardian Name: _____

_____
Patient or Parent/Guardian Signature

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature_____ Date: ___/___/___

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients,

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implanted a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

_____
Patient Signature

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PATIENT ACKOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND AUTHORIZATION/RELEASE TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION.

You may refuse to sign this acknowledgment and authorization. In refusing we **may not be allowed** to process your insurance claims.

Date: ___/___/___ Authorization to expire on ___/___/___.
*If no date is stated, the expiration date will be 12 months from the date of this authorization.

The undersigned acknowledges receipt of the currently effective Notice of Privacy Practices for **The Smile Spa of North Jersey, LLC.** A copy of this signed, dated document shall be as effective as the original. I have read and understood the terms of this authorization. I have also had the chance to ask questions about how my health information will be used and disclosed. By signing this authorization, I am affirming that to the best of my knowledge all information provided on this form is complete, accurate and consistent with my directions. I hereby provide my agreement to the terms authorizing the use and disclosure of my health information in the manner described in this form. I have the right to cancel this authorization at any time, and that the cancellation must be in writing and sent to the address noted on this form.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:
[ ] First Name Only [ ] Surname (Mrs. Smith) [ ] Other: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes spouse, stepparent, grandparent and any caretakers who can have access to this patient's records.)

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I AUTHORIZE CONTACT FROM THE SMILE SPA OF NORTH JERSEY, LLC <u>TO CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION</u> VIA:

[ ] Cell phone confirmation [ ] Text message confirmation [ ] Home phone confirmation
[ ] Work phone confirmation [ ] Email confirmation [ ] Any of the above

In signing this HIPAA Patient Acknowledge Form, you acknowledge and authorize, that this office may recommend products and services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

_____ _____
Patient Name – please PRINT your name Patient Signature

_____ _____
Legal Representative Signature (Parent/Guardian) Description of Authority (Relation to Patient)

OFFICE USE ONLY:
As Privacy Officer, I attempted to obtain the patient's (or representative's) signature of this Acknowledgment but did not because:
[ ] It was emergency treatment [ ] I couldn't communicate with patient [ ] The patient refused to sign
[ ] The patient was unable to sign because _____
[ ] Other _____

Signature of Privacy Officer _____

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.**

Oral Cancer Risk profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with any of the following:
  - Tobacco use
  - Chronic alcohol consumption
  - Oral HPV infection

Highest risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer

• 25% of oral cancers occur in people who don't smoke and have no other risk factors.

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is $90.00

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____

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PATIENT ADVISORY & ACKNOWLEDGMENT: Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please advised of the following:

While our office complies with the State Health Department and the Centers for Disease Control and Prevention Infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff members are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please truthful and candid in your answers.

_____ DATE: ___/___/___
PATIENT/RESPONSIBLE PARTY

PLEASE ANSWER YES OR NO WITH YOUR INITIALS TO THE FOLLOWING QUESTIONS:

HAVE YOU BEEN DIAGNOSED POSTIVE FOR THE COVID-19 VIRUS AT ANY TIME?	_____ YES	_____ NO
ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____ YES	_____ NO
HAVE YOU BEEN EXPOSED TO ANYONE WHO HAS BEEN DIAGNOSED WITH COVID-19 IN THE PAST 21 DAYS?	_____ YES	_____ NO
DO YOU HAVE A FEVER?	_____ YES	_____ NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____ YES	_____ NO
DO YOU HAVE A DRY COUGH?	_____ YES	_____ NO
DO YOU HAVE A RUNNY NOSE?	_____ YES	_____ NO
DO YOU HAVE A SORE THROAT?	_____ YES	_____ NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____ YES	_____ NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE OR WEAKNESS?	_____ YES	_____ NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____ YES	_____ NO
HAVE YOU VISITED OR RECEIVED TREATMENT IN A HOSPITAL, LONG-TERM CARE FACILITY, OR OTHER HEALTH CARE FACILITY IN THE PAST 30 DAYS?	_____ YES	_____ NO
ARE YOU OR ANYONE IN YOUR HOUSEHOLD A HEALTH CARE PROVIDER OR EMERGNECY RESPONDER?	_____ YES	_____ NO
WITHIN THE LAST 21 DAYS, HAVE YOU TRAVELED WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO

IF SO, WHERE? _____