

Brookdale Dental Group
Existing Patient Medical /Information Update

Patient's Name _____ Date _____
DOB _____
E-mail Address _____ Cell _____
Please list any Health Changes or new medications since your last visit. _____

Please list any updates to your Dental Insurance, Job Changes, Address, Phone # since your last visit. _____

Patient/Guardian Signature _____ Date _____

COVID-19 Acknowledgment

Please answer the following questions.

Are you currently awaiting the results of a COVID-19 test? _____
Do you have a fever? _____ Do you have shortness of breath? _____
Do you have a dry cough? _____ Do you have a runny nose? _____
Do you have a sore throat? _____ Have you lost your sense of taste/smell? _____
Do you have sneezing, water eyes, and/or sinus pain/pressure that is unusual and not related to
seasonal allergies? _____ Have you experienced headaches, fatigue or weakness? _____
Within the last 14 Days, have you travelled to any foreign country? _____
Within the last 14 days, have you travelled within the US, & if so, where? _____

Patient/Responsible Party Signature _____ Date _____

Notice of Privacy Practices

(You may Refuse to sign this Acknowledgement)

I, _____, have seen/read the copy of Brookdale Dental Group's Notice of Privacy
Patients/guardian name
Practices posted on the website and/or displayed in the office.

I, _____, I give Brookdale Dental authorization to discuss my treatment/financial
Patient's name
arrangements with, _____ relationship _____

Signature _____ Date _____