

RECERTIFICATION, CONTINUING CONSENT FOR TREATMENT, AND COVID-19 SCREENING FORM

Print Full Legal Name of Patient _____

Does Patient have a **COURT APPOINTED** Legal Guardian (LG) or **ACTIVATED** Power of Attorney (POA) ? YES NO

Print LG/POA Name : _____

LG/POA Phone #s _____

1. Does patient have a fever ? YES NO
2. Has patient been in contact with an individual diagnosed with COVID-19 in the last month ? YES NO
3. Has patient been diagnosed with COVID-19 in the last month ? YES NO
4. Has patient been tested for COVID-19 ? YES NO
5. Has patient traveled outside the U.S.A. in the last month ? YES NO
6. Is patient experiencing any respiratory problems such as abnormal coughing or shortness of breath ? YES NO

Medical Changes – Drug Changes – Other Changes :

I certify that there have been no changes in the above named patient's medical history, dental history, registration information, general information, dental insurance, or any other applicable information, except as noted below. I certify the patient has not stopped, started, or changed any prescription or over-the-counter medications, except as noted above. I certify the patient has not suffered any illnesses or injuries since the patient's last visit, except as noted above. I certify all medical treatments or consultations the patient has had since their last dental visit has been listed above. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions that may have been made in completion of this form. I hereby authorize Dr. James J. Herget and whomever he designates as his dental hygienists and assistants to perform dental treatment on the above named patient. I give my continuing consent to all advisable and necessary dental procedures needed for diagnostic purposes and dental treatment. I further consent to the administration of local anesthetics, antibiotics, analgesics, or any other drugs that may be deemed necessary by Dr. James J. Herget. I agree Dr. Herget will not be held responsible for any sub-standard treatment or complications from treatment done by another provider such as a dental specialist. I understand that female patients taking birth control pills need to find an alternative method of birth control should Dr. Herget prescribe antibiotics, as the antibiotic may inactivate the birth control pills effectiveness. I certify that the answers given to the questions asked in this **Recertification, Continuing Consent for Treatment, and COVID-19 Screening Form** are correct and the information is complete and accurate. I will not hold Dr. James J. Herget or his employees responsible for any errors or omissions made during the completion of this form.

Patient Signature (**Adult** patients only) _____ Date _____

Print Parent Name (**Minor** patients only) _____

Parent Signature (**Minor** patients only) _____ Date _____

Print Power of Attorney/Legal Guardian Name (if applicable) _____

Power of Attorney/Legal Guardian Signature (if applicable) _____ Date _____