THOMAS T. BUNKER DDS, PC
General & Family Dentistry

Emergency Patient Form

Patient Name

Date

Date of Birth

For Office Use

Temperature

For the safety of our patients and staff, and in compliance with the latest CDC guidelines please answer the following questions:

Have you traveled outside of Central New York within the last 14 days? ☐ Yes ☐ No

Have you had any signs of fever, cough, or shortness of breath in the last 72 hours? ☐ Yes ☐ No

Have you been in contact with anyone known to have COVID-19 or who is under quarantine for precaution of possible exposure within the last 14 days? ☐ Yes ☐ No

Signature

Date

Please answer these questions as completely as possible to help us know how to treat you:

How can we help you today?

What symptoms are you experiencing? (check all that apply)

☐ Hot Sensitivity ☐ Cold Sensitivity ☐ Sensitivity to Sweets ☐ Pain When Chewing ☐ Spontaneous Pain ☐ Sharp Pain
☐ Dull Pain ☐ Continuous Pain ☐ Swelling ☐ Difficulty Sleeping ☐ Other

Where do you feel the symptoms (check all that apply)

☐ Tooth ☐ Gums ☐ Cheek ☐ Lips ☐ Tongue ☐ Palate ☐ Upper Jaw ☐ Lower Jaw ☐ Right ☐ Left ☐ Other

How severe is the pain? (0-10, 0 being no pain and 10 being debilitating pain)

How long has this condition existed?

What are you doing to manage this condition?