Tandheelkundigcentrum Dewever - Wouters

Mandatory to be completed before every dental visit

Covid 19-questionnaire

Dear patient,

Due to COVID-19, we are obliged to ask you to complete this questionnaire so that the dental treatment can be carried out in a safe manner.

Name en surname: .....

Date of birth (DD/MM/YYYY): . . / . . / . . . .

(If you do not have your e-ID with you, your national registration number:

___ . ___ . ___ - _____ . ___)

Have you been through a COVID-19 infection in the past 2 weeks? ☐ Yes ☐ No

Do you have one or more of the following symptoms? (Tick which one.)

- ☐ A cold
- ☐ Sneezing
- ☐ Coughing
- ☐ Loss of taste/odor
- ☐ Sore throat
- ☐ Shortness of breath
- ☐ Fever (over 37,3°C)
- ☐ Severe muscle pain or fatigue

Have you had a high-risk contact in the past two weeks? ☐ Yes ☐ No
If yes, have you been tested for Covid-19 yourself? ☐ Yes ☐ No
If yes, what was the result of the test? ☐ Positive ☐ Negative

I declare that I have answered the above questions truthfully.

Date: . . / . . / . . . . Signature: .....

To be completed once (Ignore this if you have already filled it in)

Questionnaire Medical Background

Dear patient,

During dental treatment it is necessary that your dentist is aware of your general health. Please fill in the questionnaire below.

Do you smoke …? (Check what applies to you.)
☐ Cigar(ette)s ☐ Vape ☐ Cannabis ☐ Pipe ☐ Other

Have there been any changes in your general health since your last dental visit? *(For example: heart/lung/liver/kidney disease, allergies, HIV, pregnancy, etc.)*

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Have you been taking any new medication since your last visit? ☐ Yes ☐ No
If so, which medication (i.e. for what)?

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Would you like to receive your invitation for a periodic check by letter or e-mail? (Tick.)

☐ Letter. ☐ E-mail, to e-mail address: .....

With this form, I give permission to the employees of the Dewever-Wouters association to store data that is necessary for making a diagnosis, performing and following up treatments and associated invoicing. I also give permission to share all necessary information with third parties in the context of further dental treatments.

Date: . . / . . / . . . . Signature: .....