Patient Advisory and Acknowledgment Receiving Routine 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 be 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 COVID-19 virus, we cannot make any guarantees. Our staff 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 be truthful and candid in your answers.

_____ _____

PATIENT/RESPONSIBLE PARTY **DATE**

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITITALS, TO THE FOLLOWING QUESTIONS

HAVE YOU BEEN DIAGNOSED POSITIVE 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 HAD CONTACT WITH SOMEONE WHO WAS DIAGNOSED WITH COVID-19? _____YES _____NO

CURRENTLY OR IN THE PAST 14 DAYS:

HAVE YOU HAD CONTACT WITH SOMEONE EXPOSED TO COVID-19? _____YES _____NO

HAVE YOU HAD CONTACT WITH SOMEONE EXPERIENCING SYMPTOMS OF COVID-19? _____YES _____NO

DO YOU HAVE A FEVER? _____YES _____NO

DO YOU HAVE ANY SYMPTOMS OF A FEVER? DO YOU HAVE CHILLS, SWEATING OR FEEL HOT? _____YES _____NO

DO YOU HAVE A COUGH? _____YES _____NO

DO YOU HAVE SHORTNESS OF BREATH, OR DIFFICULTY BREATHING? _____YES _____NO

DO YOU HAVE CONGESTION, RUNNY OR STUFFED NOSE, OR REDNESS IN YOUR EYES? _____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, MUSCLE OR BODY ACHES, OR WEAKNESS? ----------YES ----------NO

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? ----------YES ----------NO

DO YOU HAVE ANY GASTROINTESTINAL SYMPTOMS, NAUSEA, VOMITING, DIARRHEA? ----------YES ----------NO

HAVE YOU EXPERIENCED ANY NEUROLOGICAL SYMPTOMS, INCLUDING CONFUSION? ----------YES ---------NO

WITHIN THE LAST 14 DAYS HAVE YOU TRAVELLED, EITHER WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY? IF SO, WHERE? _____ ----------YES ----------NO