Patient Advisory and Acknowledgment Form

Receiving 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 State Health Department and Centers for Disease Control and Prevention infection control guidleines to prevenet the spread of the COVID-19 virus, we cannot make any gurantees.

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 accomodation, 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 INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST	YES NO
DO YOU HAVE A FEVER?	YES NO
ARE YOU TAKING ANY FEVER REDUCING MEDICATIONS?	YES NO
DO YOU HAVE ANY SHORTNESS OF BREATHE?	YES NO
DO YOU HAVE A DRY COUGH?	YES NO
DO YOU HAVE A RUNNY NOSE?	YES NO
DO YOU HAVE A SORE THROAT?	YES NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSAUL AND NOT RELATED TO SEASONAL ALLERGIES?	YES NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	YES NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	YES NO
WITHIN THE LAST 14 DAYS , HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	YES NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?	YES NO

IF SO WHERE?